



# It Doesn't Have to be This Way

Lisa C. Richardson, MD, MPH  
*Director, Division of Cancer Prevention and Control, CDC*

N.C. Public Health Leaders Conference  
January 23, 2020



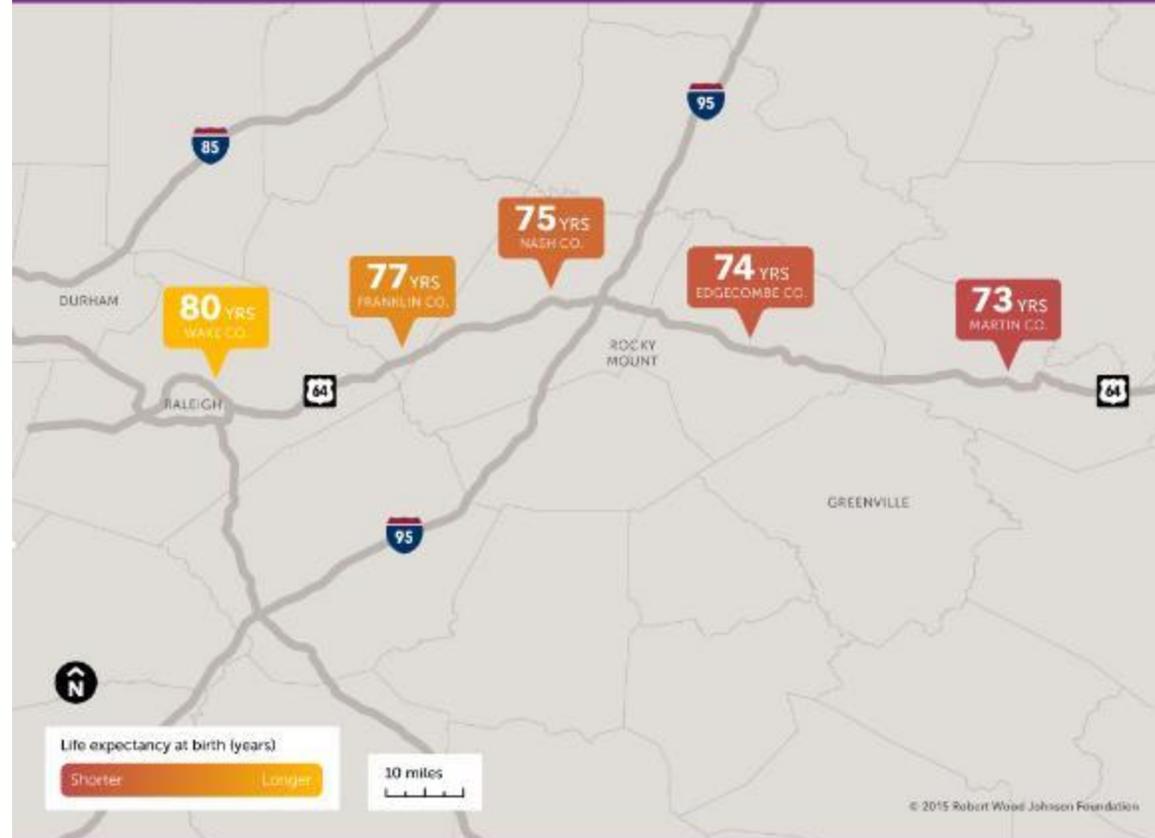


NORTH CAROLINA

## 1 Highway, 5 Counties, 7 Years of Life

Follow the discussion

#CloseHealthGaps



Source: [www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html](http://www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html)

# Health Equity Challenges Rooted Nation's Past



1863

1868

1964



Mary Wolcott

PRESENTED AT: **2019 ASCO**  
ANNUAL MEETING

**#ASCO19**  
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PRESENTED BY: YOUSUF ZAFAR, MD, MHS, FASCO @yzafar



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# Health Disparities Gain National Focus

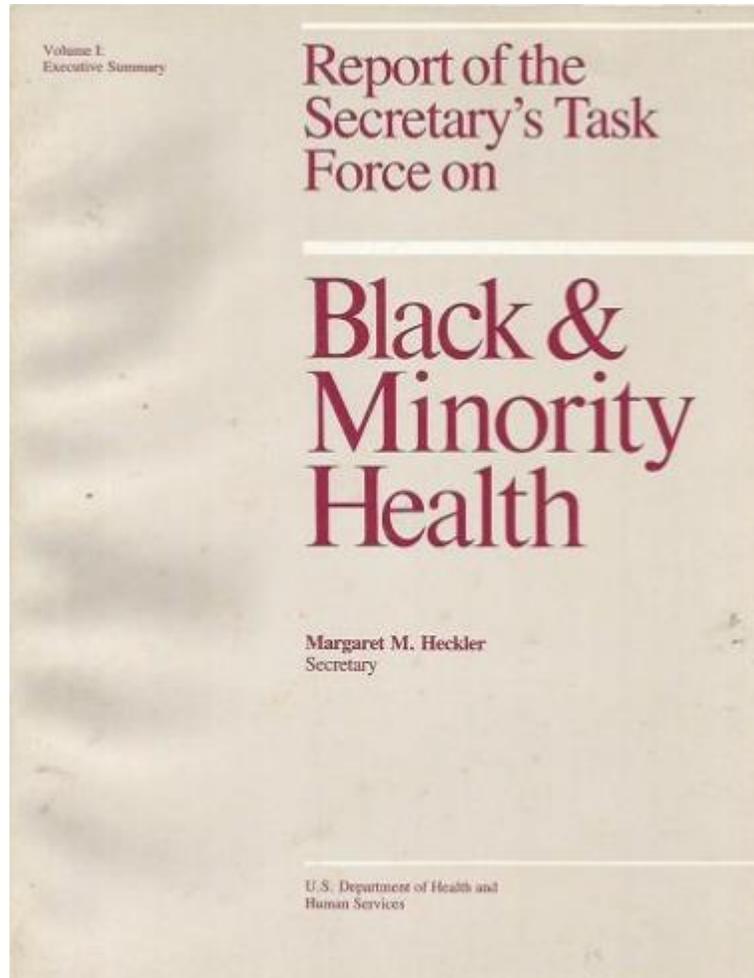
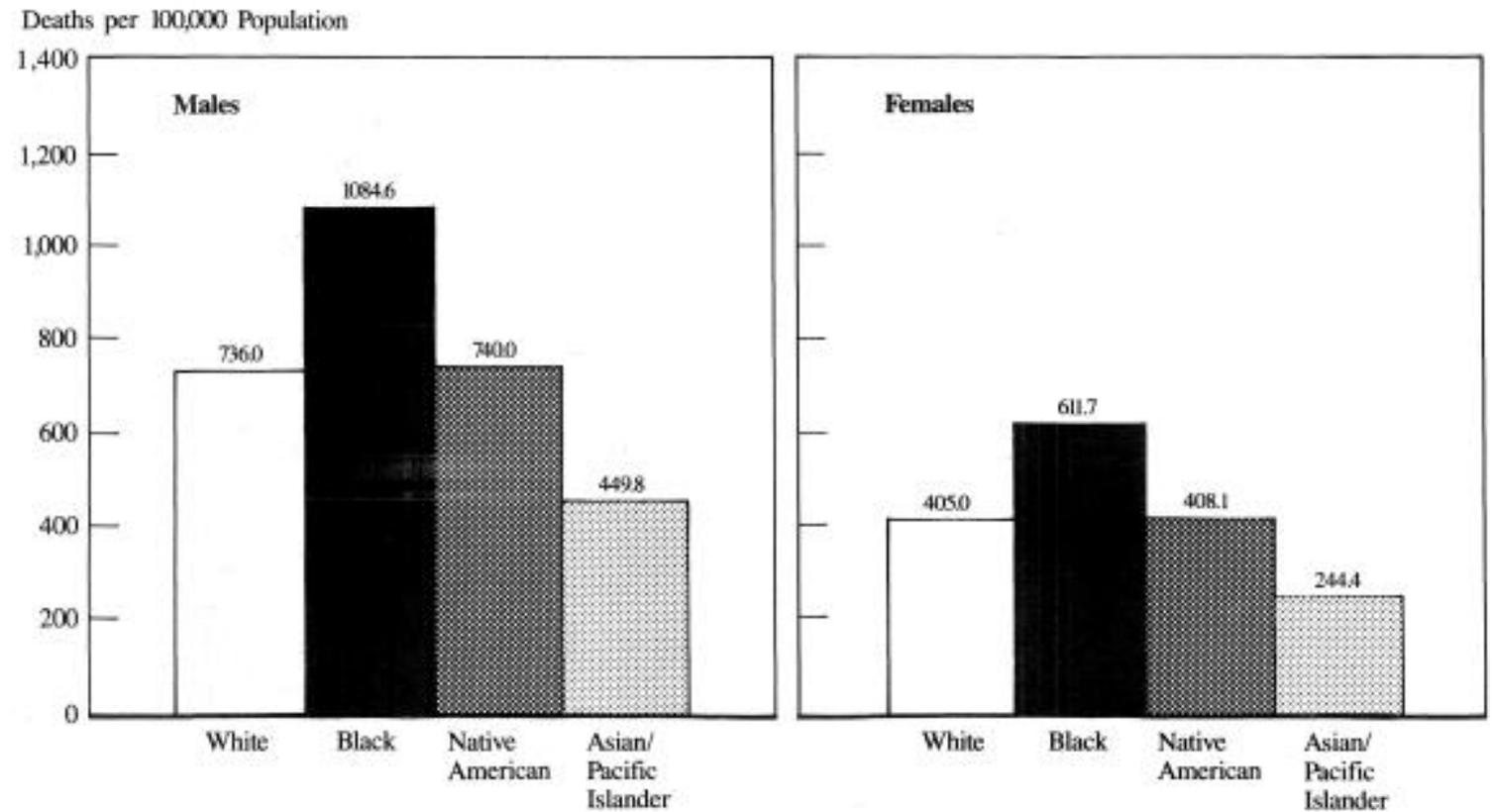


Figure 1  
Average Annual Age-Adjusted Death Rates  
for All Causes, 1979-1981



# Progress and Opportunities



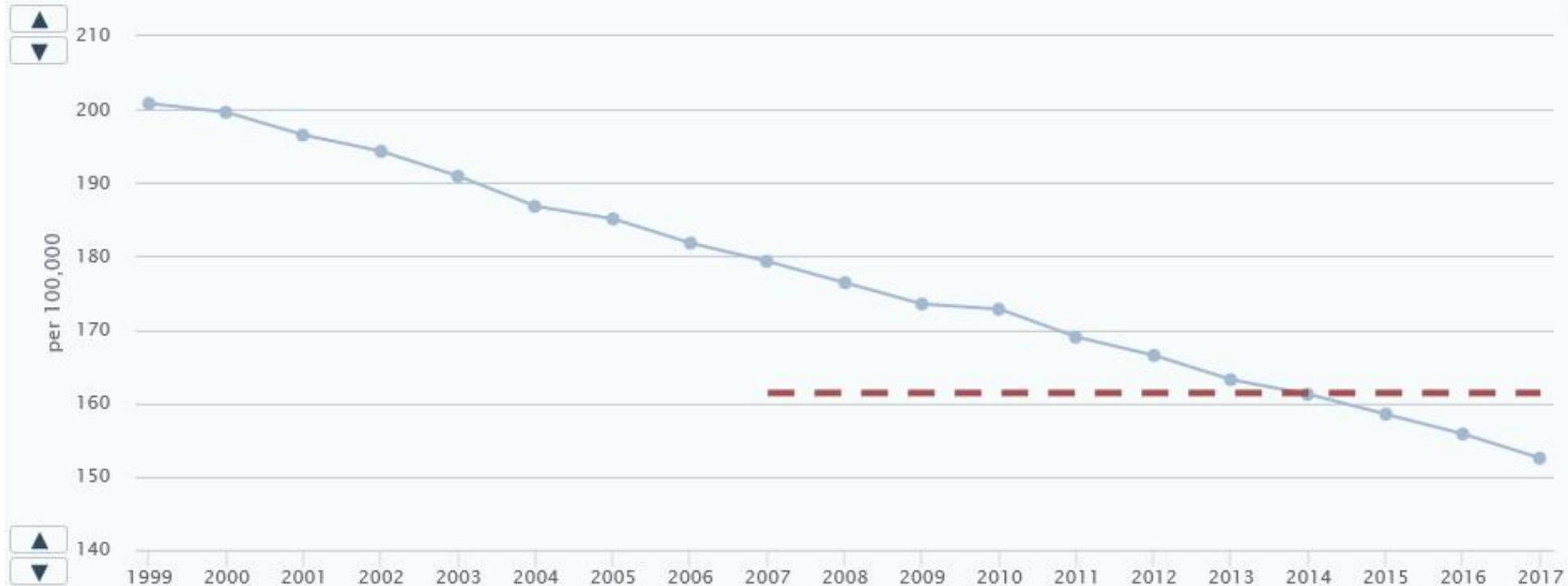
# Deaths from Cancer Continue to Decline

Overall cancer deaths (age-adjusted, per 100,000 population)  
By Total

2020 Baseline (year): 179.3 (2007) — 2020 Target: 161.4 Desired Direction: ↓ Decrease desired



Auto Scale



CDC National Center for Health Statistics; healthypeople.gov

—●— Total

# Cancer Advances not Benefitting all Equally

Age-Adjusted Cancer Death Rates for Blacks and Whites, Selected Years 1950-2016

	1950	1960	1970	1980	1990	2000	2010	2016
White	194.6	193.1	196.7	204.2	211.6	197.2	172.4	156.6
Black	176.4	199.1	225.3	256.4	279.5	248.5	203.8	177.9
Difference	-18.2	6.0	28.6	52.2	67.9	51.3	31.4	21.3
Ratio	.9	1.0	1.2	1.3	1.3	1.3	1.2	1.1

SOURCE: National Center for Health Statistics, Health, United States 2017.

NOTES: Deaths per 100,000 population, "Difference" is calculated as black death rates minus white deaths rates for each cause of death. "Ratio" refers to the ratio of black deaths to white deaths.

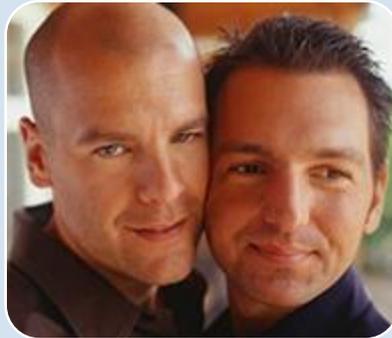
Adapted from Williams & Jackson

<https://doi.org/10.1377/hlthaff.24.2.325>

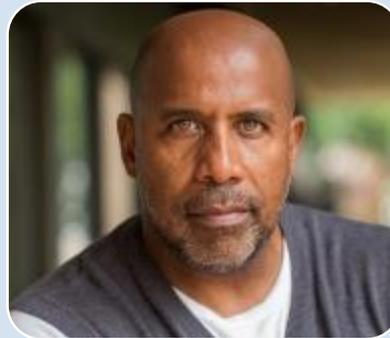
# Despite Progress, Disparities Persist



African American Women are twice as likely as white women to be diagnosed with and die from triple negative breast cancer \*



Sexual minority cancer survivors have poorer care access quality of life than their heterosexual counterparts \*\*



African American men die more often from prostate cancer than any other racial/ethnic group +



Women in rural areas have higher incidence and death from cervical cancer than women in metro areas ++



Asian and Pacific Islanders are more likely than any other racial/ethnic group to die from liver cancer +++

# Cancer Health Disparities Defined

- **NCI defines as:**

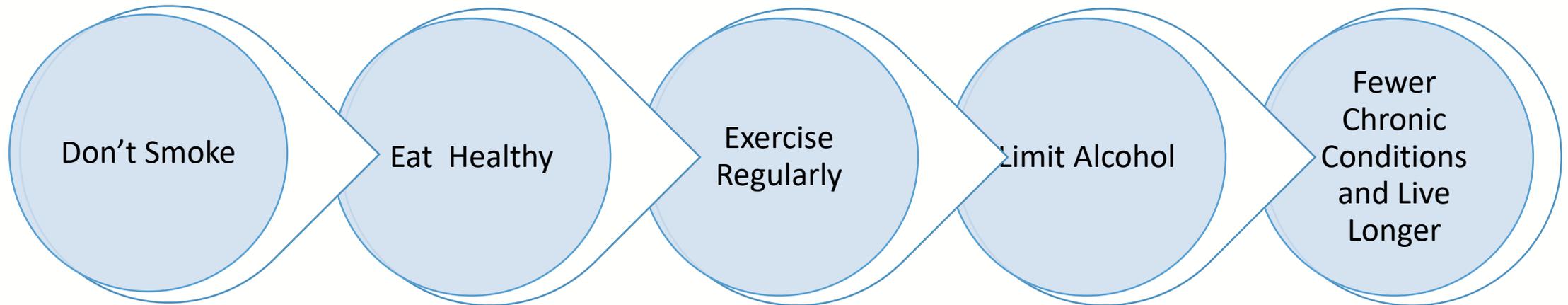
*adverse differences in cancer incidence, prevalence, death, survivorship or burden of cancer or related health conditions that exist among **specific population groups** in the United States.*

- **Population groups:**

- age,
- disability,
- education,
- ethnicity,
- gender,
- geographic location,
- income, or
- race.



# Lifestyle Factors influence Health and Wellbeing



Ford et al, Am J Public Health. 2011;101:1922–1929. doi:10.2105/AJPH.2011.300167

# What is “modifiable”

## Non-modifiable

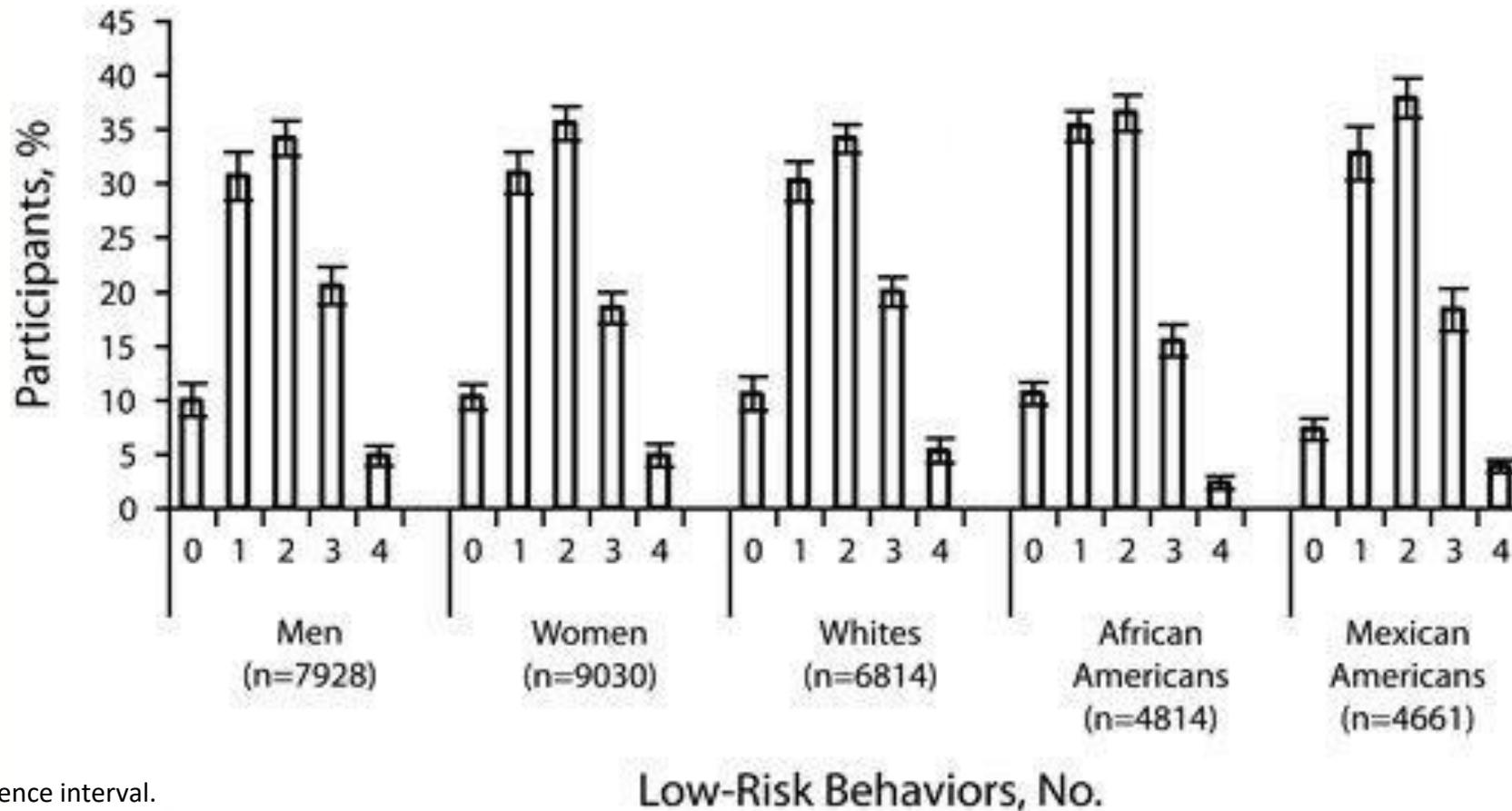
- Age
- Race/ethnicity
- Genetics
- Poverty

## Potentially modifiable

- Factors that accelerate aging
- Policies that prohibit discrimination
- Gene expression (epi-genetics)
- Educational and economic opportunities

# Impact of Low-risk Lifestyle Behaviors on Health

Distribution of low-risk lifestyle behaviors among participants aged 17 years or older at baseline: National Health and Nutrition Examination Survey III Mortality Study, United States, 1988–2006.



Bars represent 95% confidence interval.

Ford et al. Am J Public Health. 2011;101:1922–1929. doi:10.2105/AJPH.2011.300167

# Powerful Benefit of Low Risk Lifestyle Factors

- Mortality from malignant neoplasms  
AHR=0.34; 95% CI=0.20, 0.56 [4 low risk factors versus none]
- 4 high risk lifestyle factors accounted for 14.4 years of chronological age for malignant neoplasms
- Population attributable fraction was 34% for mortality for malignant neoplasms (using the category of no high risk behaviors as referent)

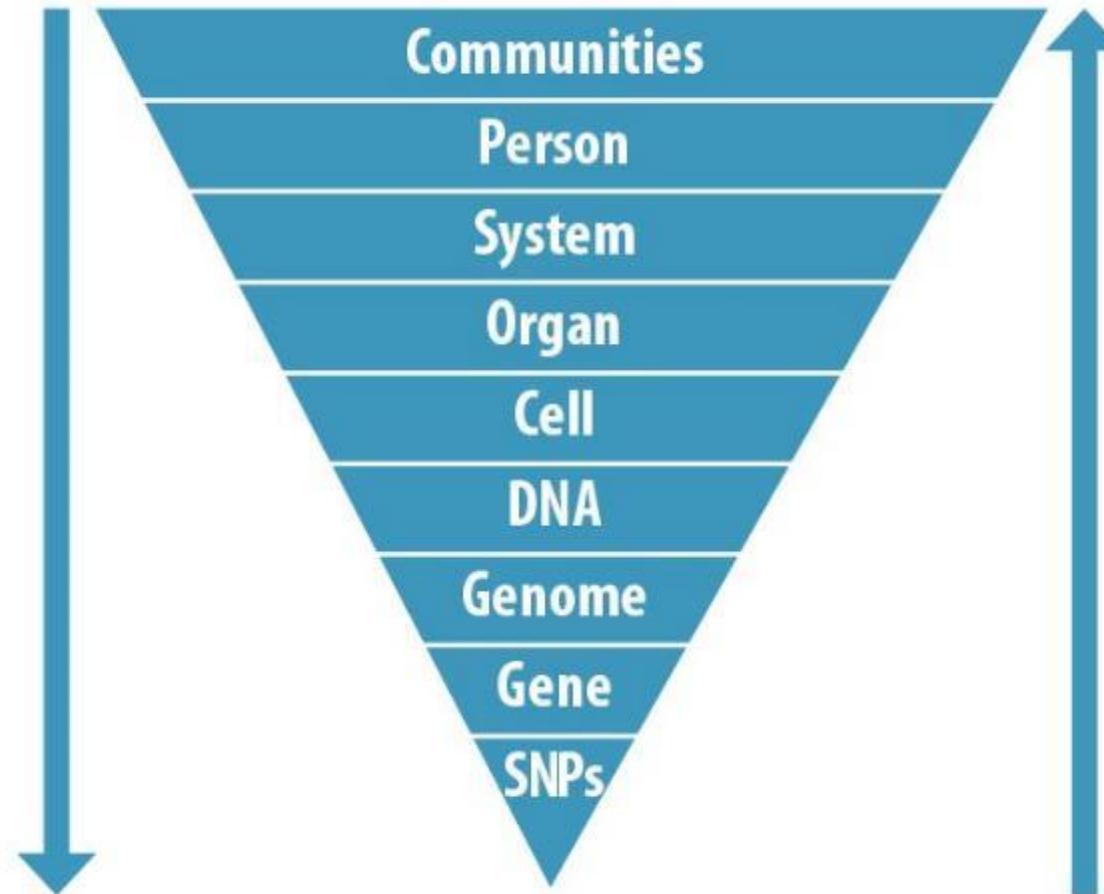


# How Social Determinants Impact Health

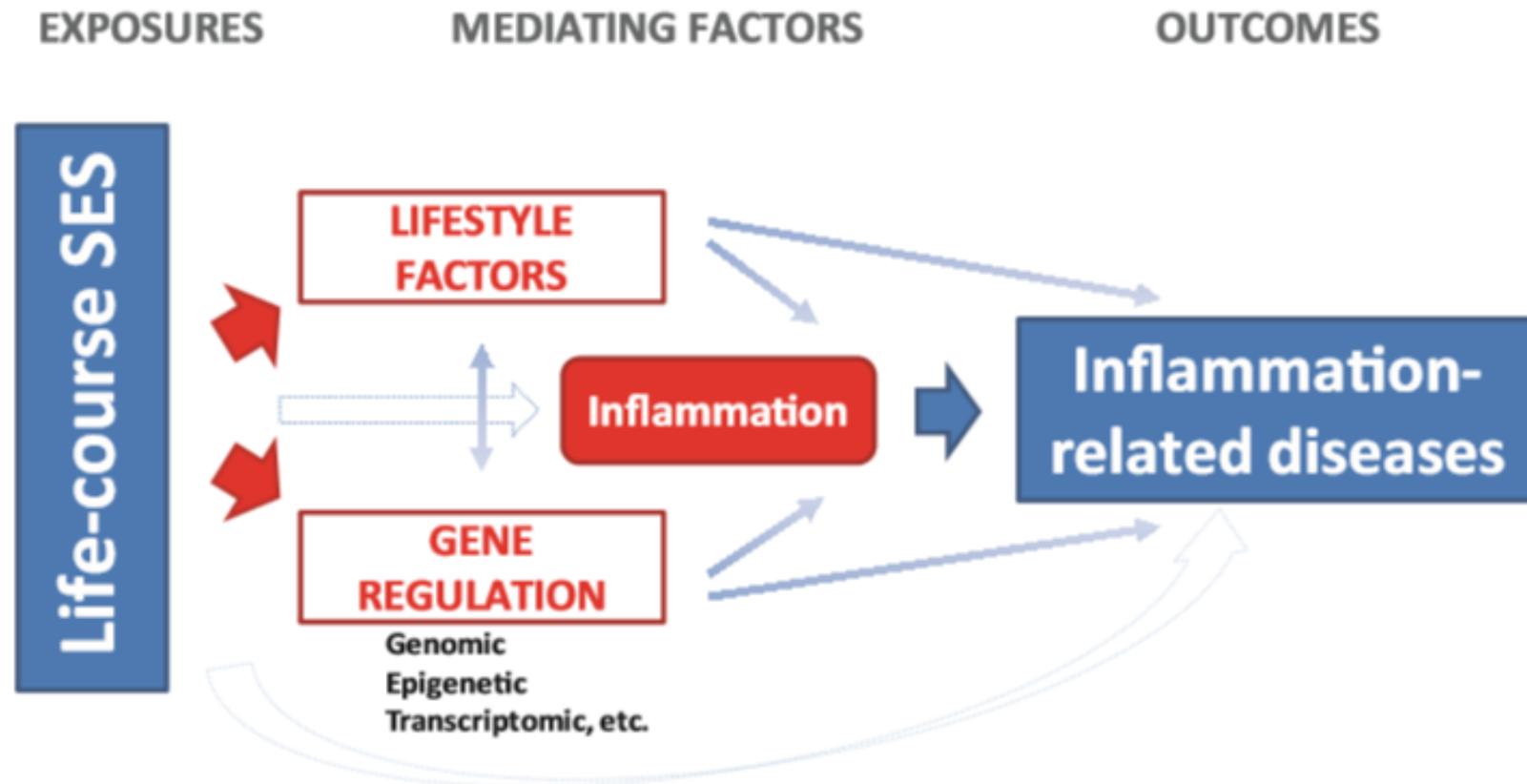


Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

# Population-Based Approach to Individualized Care



# Life-course Exposures Create Physiological Changes



Closing the Gaps with Population Impact



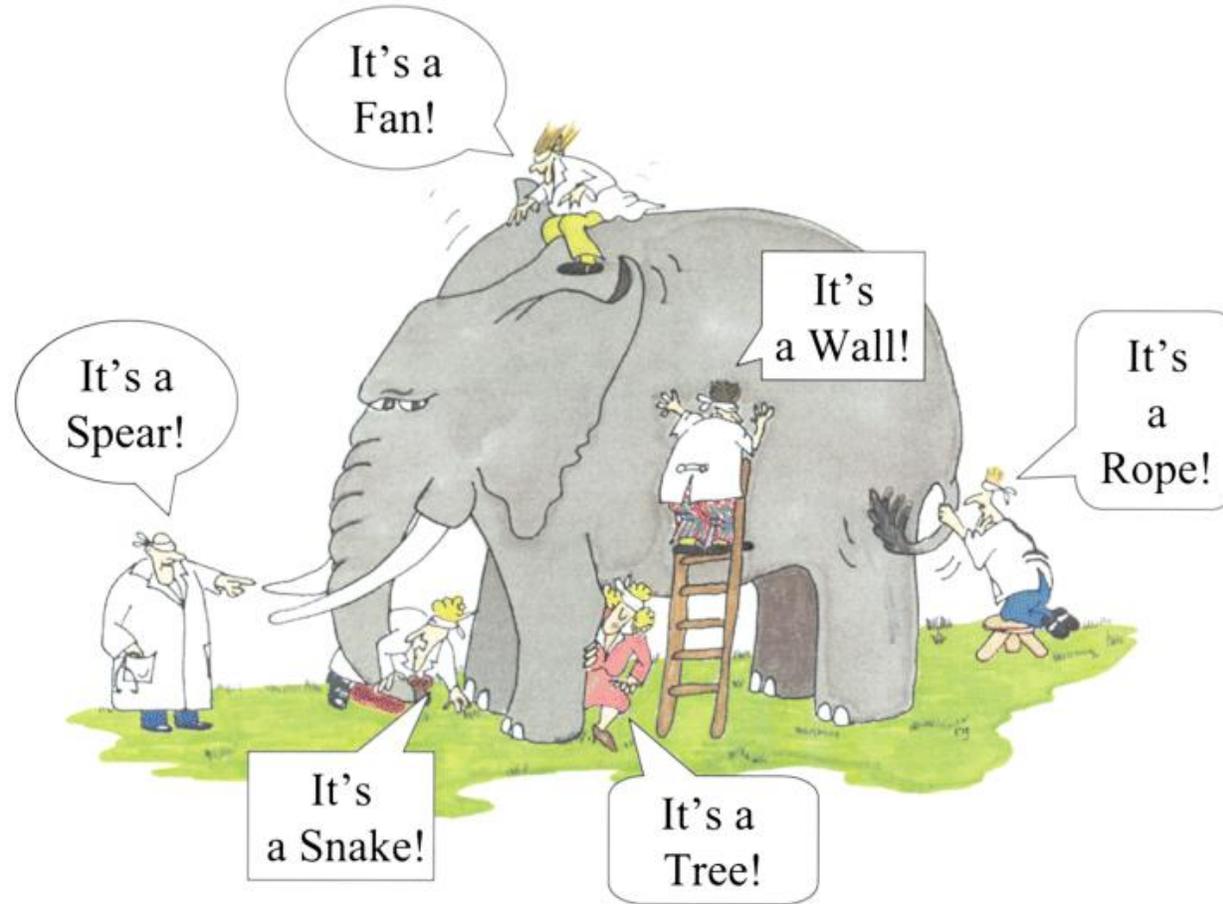
# Health Outcomes Overall Still Less than Ideal

United States lags behind peer nations in efficiency, access, equity and outcomes

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING</b>	2	9	10	8	3	4	4	6	6	1	11
Care Process +	2	6	9	8	4	3	10	11	7	1	5
Access +	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency +	1	6	11	6	9	2	4	5	8	3	10
Equity +	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes +	1	9	5	8	6	7	3	2	4	10	11

Schneider, Eric C, et al. "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care: Commonwealth Fund." Mirror, Mirror 2017: International Comparison, The Commonwealth Fund, <https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and>.

# Population-Level Benefits of Prevention Require Multi-sector/disciplinary Collaborations

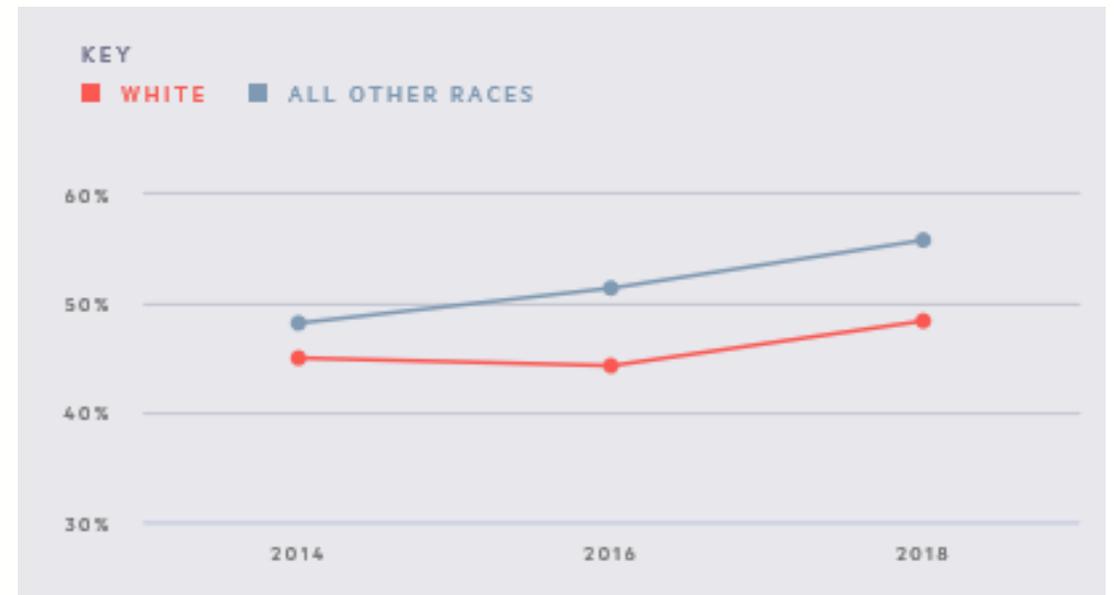


# Comprehensive Public Health Systems

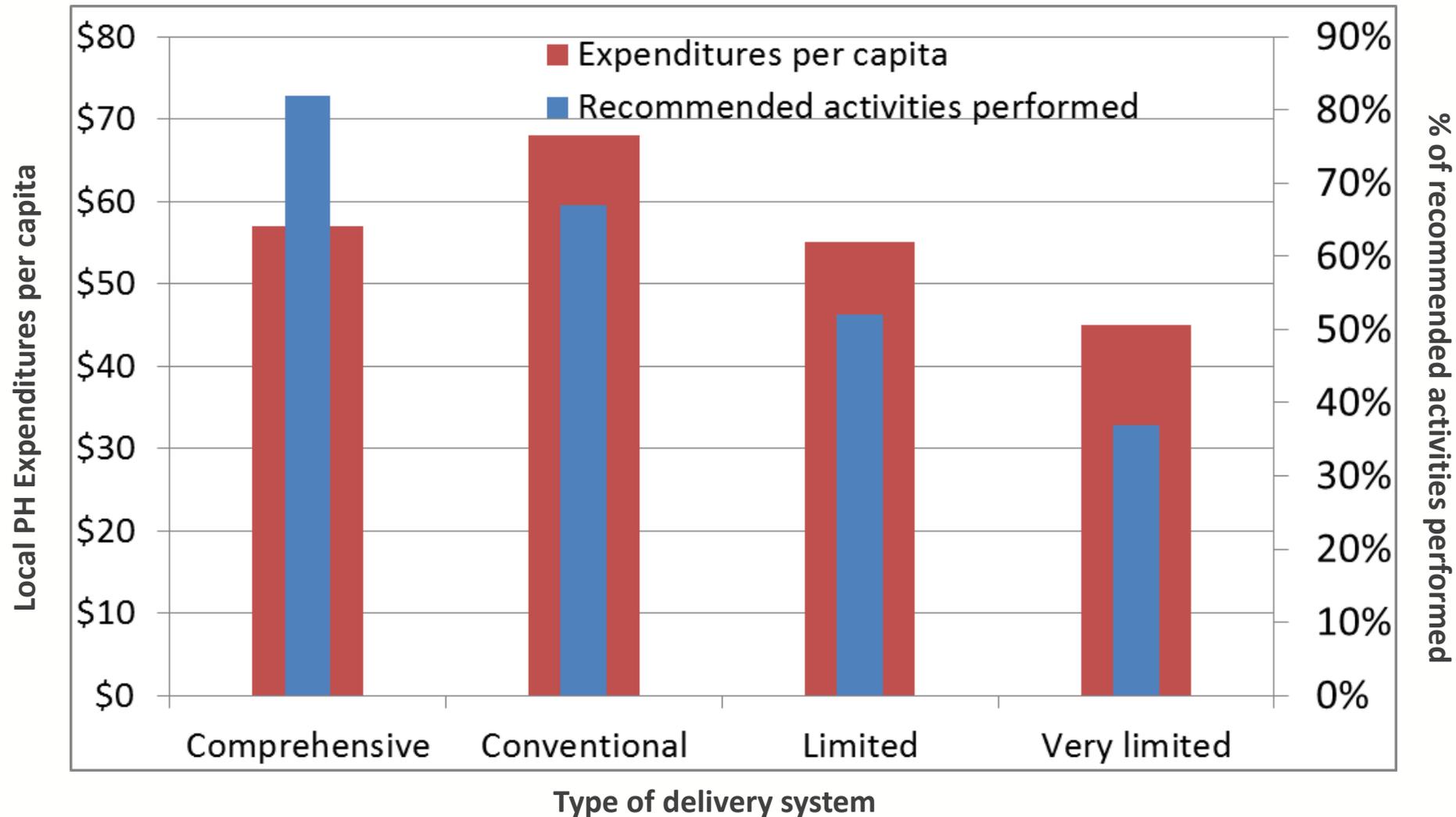
Robert Wood Johnson Foundation Culture of Health National Metrics:

- Implement a **broad scope** of population health activities
- Through **dense networks** of multi-sector relationships
- Including **central actors** to coordinate actions

**51%** of U.S. population served by a comprehensive public health system in 2018



# Comprehensive Systems do More with Less



Mays GP, Hogg RA. Economic shocks and public health protections in US metropolitan areas. Am J Public Health. 2015;105 Suppl 2:S280-7.

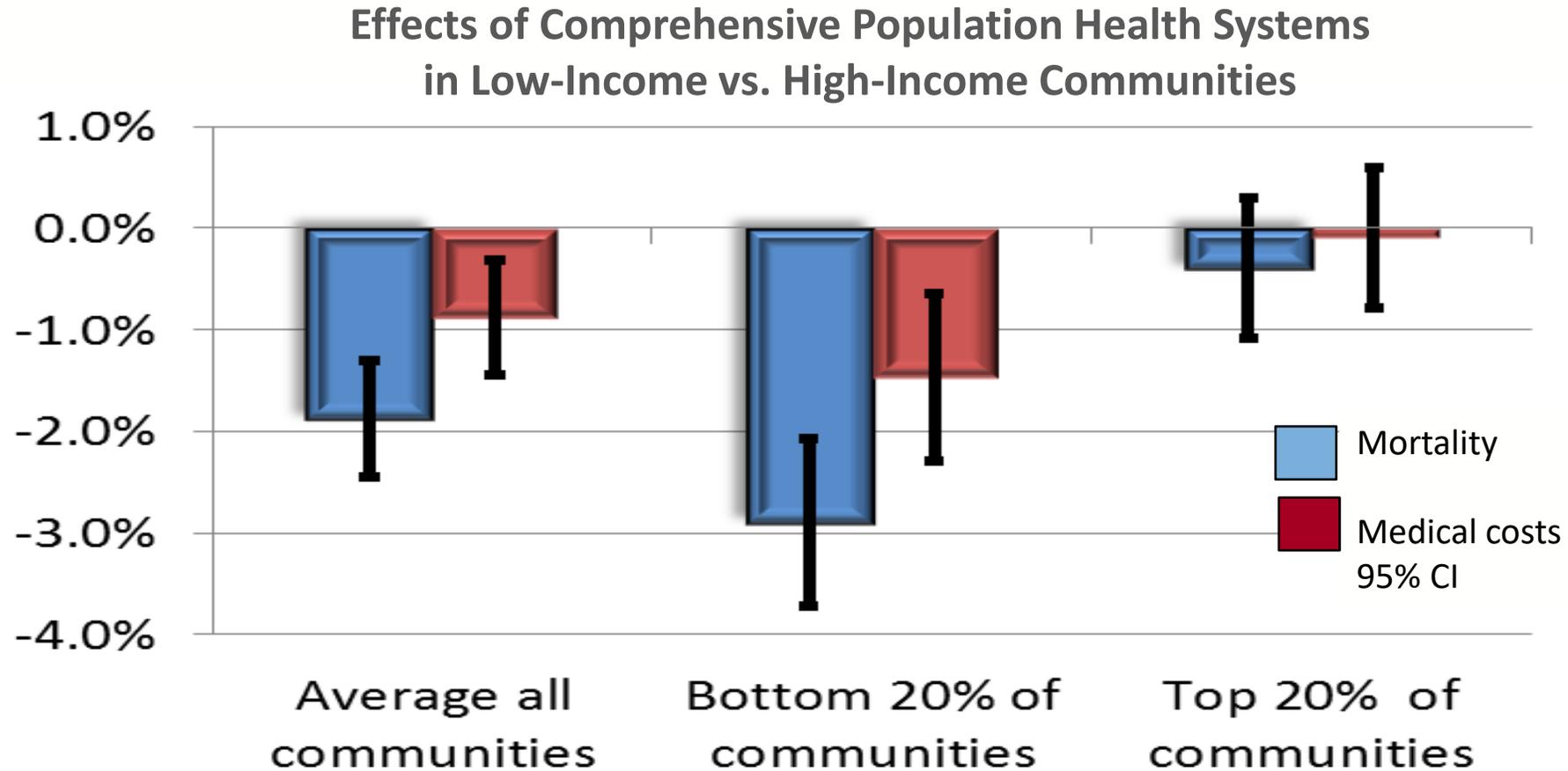
# Economic Effects Attributable to Multi-Sector Work

Impact of Comprehensive Systems  
on Life Expectancy by Income (Chetty), 2001-2014



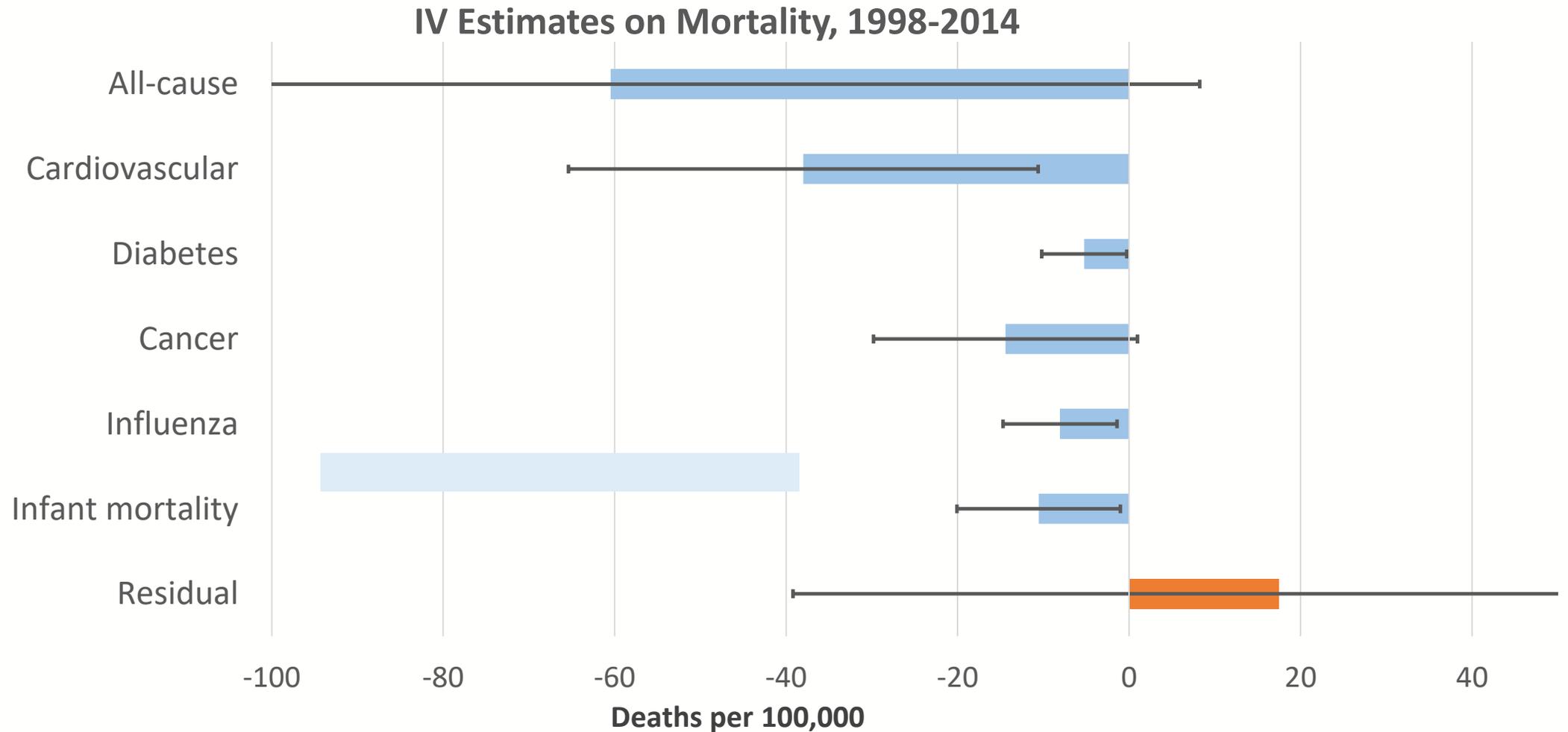
Models also control for racial composition, unemployment, health insurance coverage, educational attainment, age composition, and state and year fixed effects. N=1019 community-years. Vertical lines are 95% confidence intervals

# The Case for Equity: Larger Gains in Low-Resource Communities



Mays GP, Hogg RA. Economic shocks and public health protections in US metropolitan areas. Am J Public Health. 2015;105 Suppl 2:S280-7. Log IV regression estimates controlling for community-level and state-level characteristics

# Impact of Comprehensive Systems on Health



Mays GP, Hogg RA. Economic shocks and public health protections in US metropolitan areas. *Am J Public Health*. 2015;105 Suppl2:S280-7. Models also control for racial composition, unemployment, health insurance coverage, educational attainment, age composition, and state and year fixed effects. N=1019 community-years

**What is CDC Doing?**



# Focusing on the Social Determinants of Health



*“Today, a person’s zip code is a stronger determinant of their health than their genetic code”*



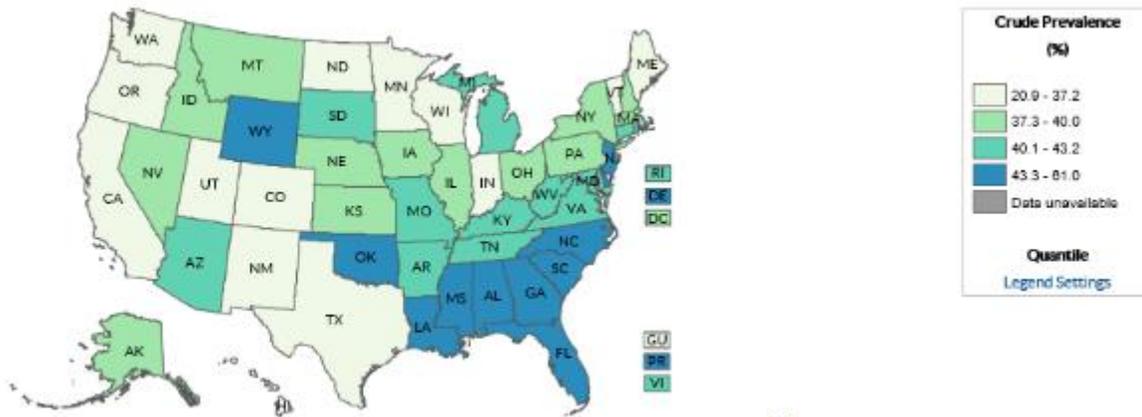
# Behavioral Risk Factor Surveillance System

Gaining Insight into the Health and Wellness of the LGBT Community

## Prevalence Trends and Data

Men aged 40+ who have had a PSA test within the past two years (variable calculated from one or more BRFSS questions) (Crude Prevalence)

View by: Overall  
Response: Yes



[www.cdc.gov/brfss/index.html](http://www.cdc.gov/brfss/index.html)

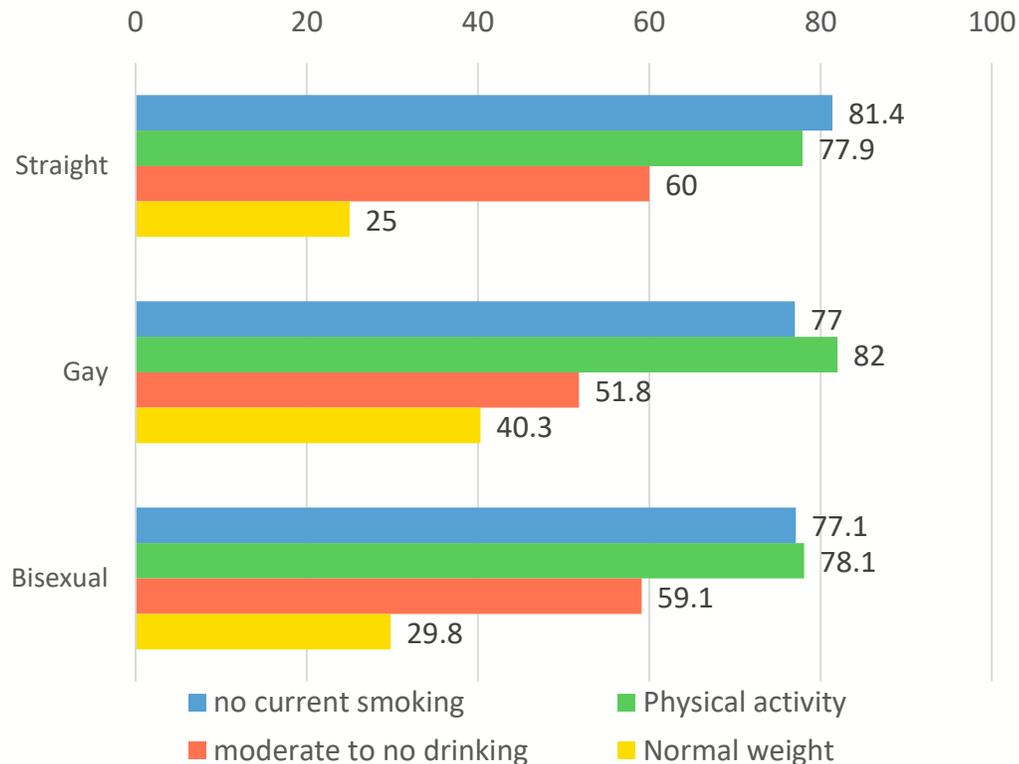
**2017 BRFSS Data Now Available**

**Related Links**

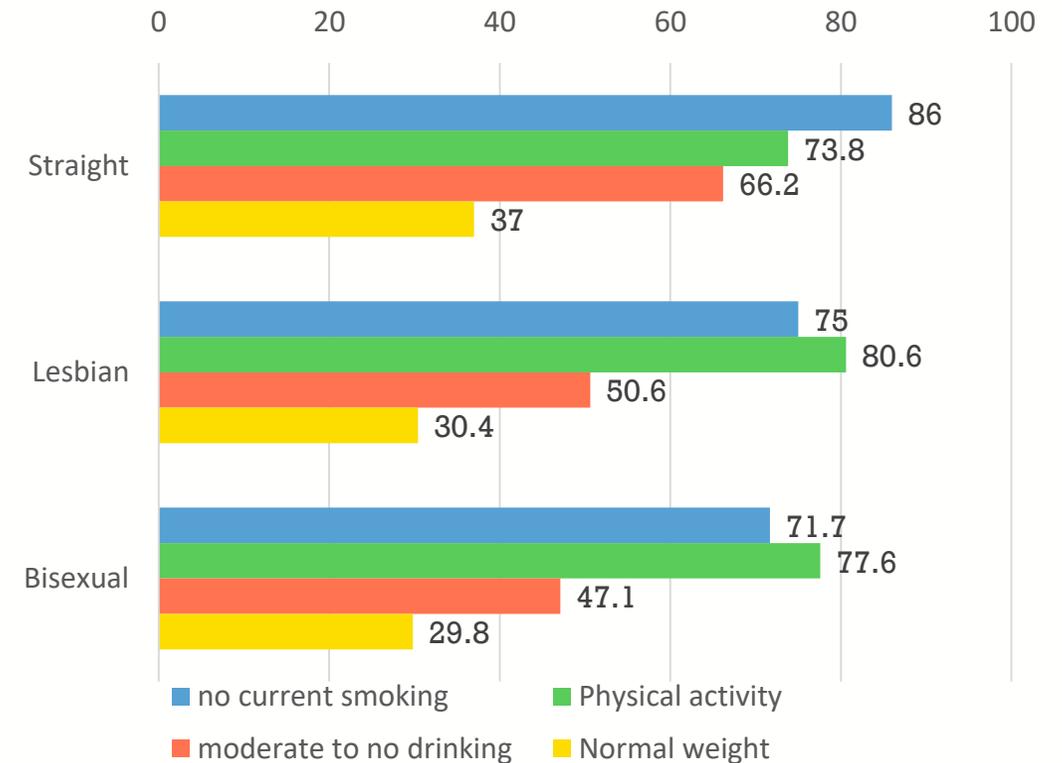
- [Health Indicator Sortable Stats](#)
- [Health Indicators Warehouse \(HIW\) ?](#)
- [HealthData.gov ?](#)
- [Data Catalog](#)
- [CDC's Major Disease Surveillance Systems](#)

# BRFSS Studies

Distribution of Health-related behaviors in men aged ≥ 25 years, by sexual orientation



Distribution of Health-related behaviors in women aged ≥ 25 years, by sexual orientation



Cunningham TJ, Xu F, Town M. Prevalence of Five Health-Related Behaviors for Chronic Disease Prevention Among Sexual and Gender Minority Adults – 25 U.S. States and Guam, 2016. MMWR Morb Mortal Wkly Rep. 2018 Aug 17; 67(32): 888–893.

# County-Level Data

Small Area Health Insurance Estimates (SAHIE) demographic, economic, and insurance insights aid surveillance efforts

- Highlights local variation
- Provides better understanding of cancer control efforts and impacts
- Enables more targeted interventions

[census.gov/programs-surveys/sahie.html](https://census.gov/programs-surveys/sahie.html)

**Small Area Health Insurance Estimates: 2017**  
Small Area Estimates  
**Current Population Reports**  
By Lauren Bowers and Carolyn Gamm  
P50-05  
April 2018

**INTRODUCTION**  
This report provides a summary of the 2017 release of the U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program.<sup>1</sup> SAHIE are the only source of data for single-year estimates of health insurance coverage status for all counties in the United States by selected economic and demographic characteristics (see text box "Small Area Health Insurance Estimates").<sup>2</sup>  
The 1-year American Community Survey (ACS) provides detailed estimates of health insurance coverage for counties with populations of 65,000 or more.<sup>3</sup> As a data enhancement to the ACS, the SAHIE model-based estimates are a vital source of information for measuring year-to-year change in health insurance coverage at the county level. The data presented in this report show changes in health insurance coverage between 2016 and 2017, as well as changes in health insurance coverage between 2013 and 2017. In addition, it presents results on the differences in coverage among selected demographic groups.

**HIGHLIGHTS**

- Among the population under age 65, the estimated county uninsured rate in 2017 ranged from 2.3 percent to 33.7 percent. The median county uninsured rate was 10.6 percent.
- In 2017, 38.4 percent of counties (1,206 counties) had an estimated uninsured rate at or below 10 percent for the population under age 65.
- From 2016 to 2017, for the population under age 65, over 91 percent of counties (2,879 counties) did not have a statistically significant change in their uninsured rate. Among counties that experienced change in their uninsured rates, more saw an increase (183 counties) than a decrease (79 counties).

**OVERVIEW OF SAHIE**  
Each year, the SAHIE program releases timely, reliable estimates of health insurance coverage for both the insured and uninsured populations in the United States by state and county.<sup>4</sup> Federal agencies and programs use SAHIE data to determine eligibility for public health services. In fact, the SAHIE program is partially funded by the Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention.

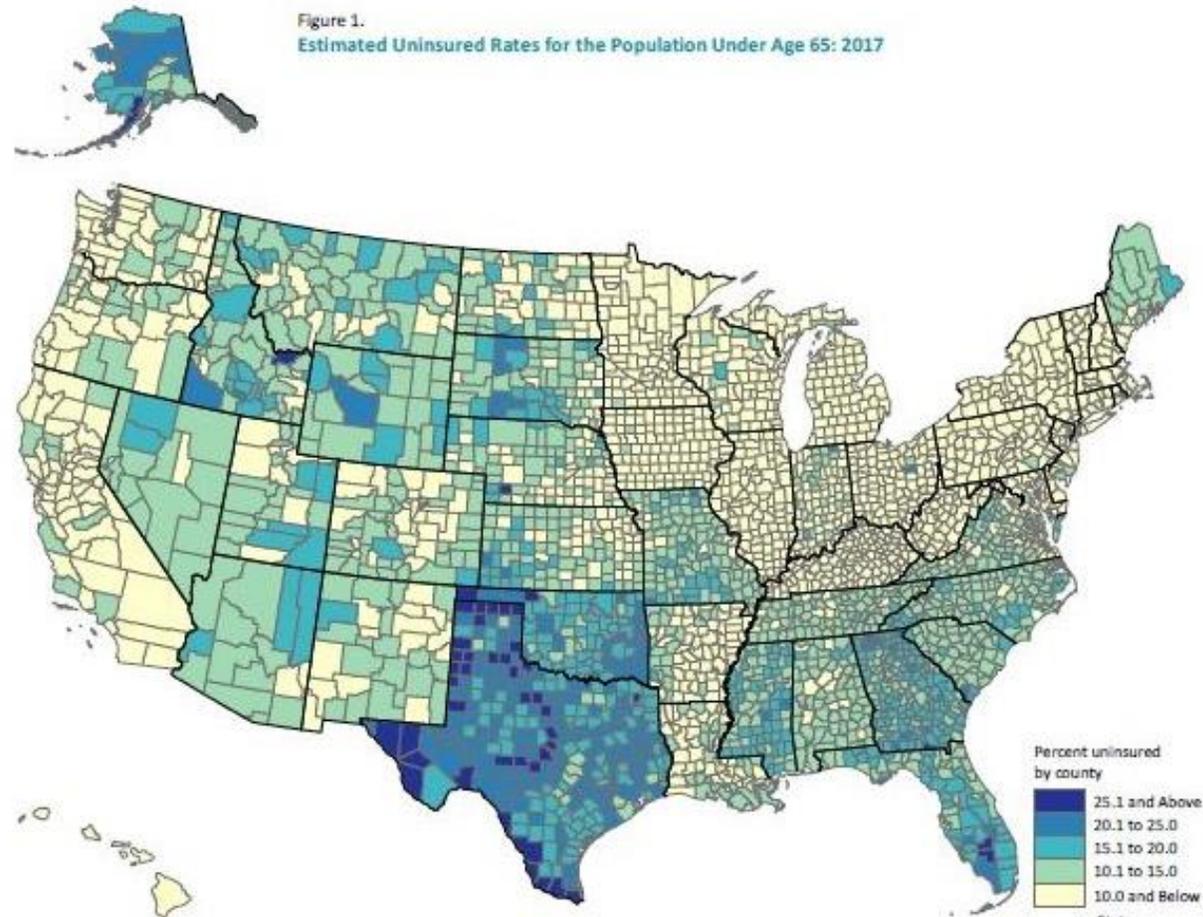
<sup>1</sup>The Census Bureau's Disclosure Review Board and Disclosure Avoidance Officers have reviewed this data product for unauthorized disclosure of confidential information and have approved the disclosure avoidance practices applied in this release. CIGORS F-Y18-016.  
<sup>2</sup>There are 3,142 counties in the United States. The SAHIE program does not include Halesowen County, W. Va., due to insufficient data.  
<sup>3</sup>Approximately 73.7 percent, or 2,430 of U.S. counties, do not have detailed 1-year estimates of health insurance coverage. However, the ACS 1-year county-level estimates cover about 80.2 percent of the total U.S. population. It should be noted that the ACS releases 1-year supplemental tables of health insurance coverage estimates for geographic areas with populations greater than 20,000; however, these tables do not provide the same economic and demographic detail as SAHIE.  
<sup>4</sup>Please refer to the detailed definition of the insured population at [www.census.gov/programs-surveys/sahie/about/faq.html](https://www.census.gov/programs-surveys/sahie/about/faq.html).

United States<sup>®</sup>  
**Census**  
Bureau

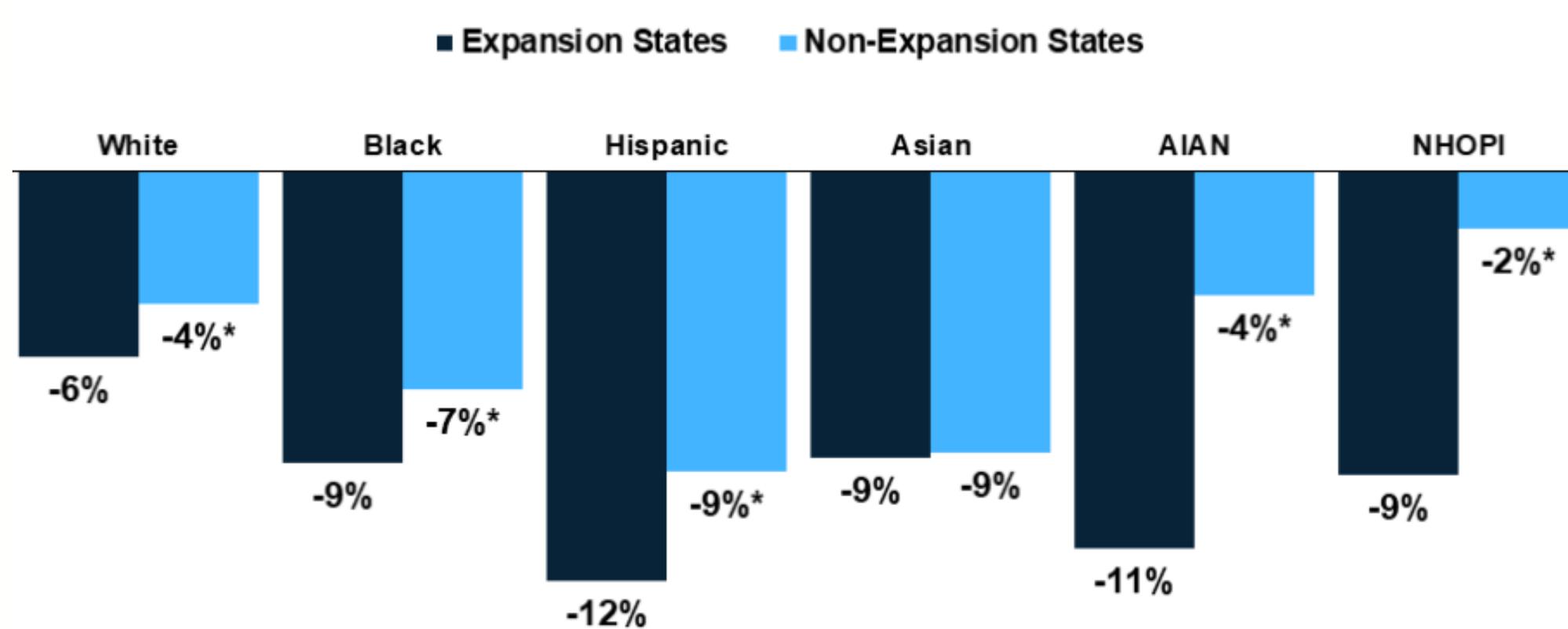
U.S. Department of Commerce  
Economic and Statistics Administration  
U.S. CENSUS BUREAU  
[census.gov](https://www.census.gov)

# U.S. Census Bureau - Uninsured Population Age 65 Under

## 2017 Small Area Health Insurance Program

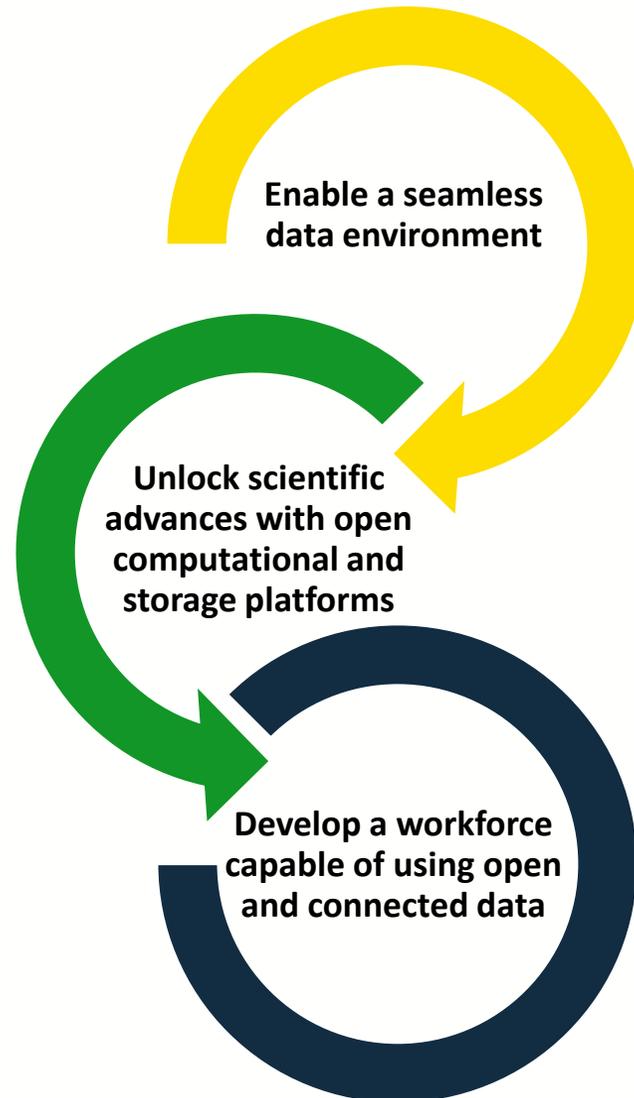


# Change in Uninsured Rates by Race/Ethnicity and State Medicaid Expansion, 2013-2017



Kaiser Family Foundation, *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*

# Unleashing the Power of Data



If you build it ....

.... make it easy and relevant to use ....

.... we will come.

# CDC's National Program of Cancer Registries



1.66 million	New cancer cases each year
200+ data items for each case	Cancer site and histology Patient demographics Stage at diagnosis First course of treatment



## WHO

is getting cancer (for instance, by race, age, or sex)?



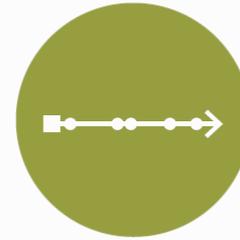
## WHAT

types of cancer are increasing or decreasing?



## WHERE

will prevention efforts have the biggest impact?



## WHEN

are screening or prevention strategies working?



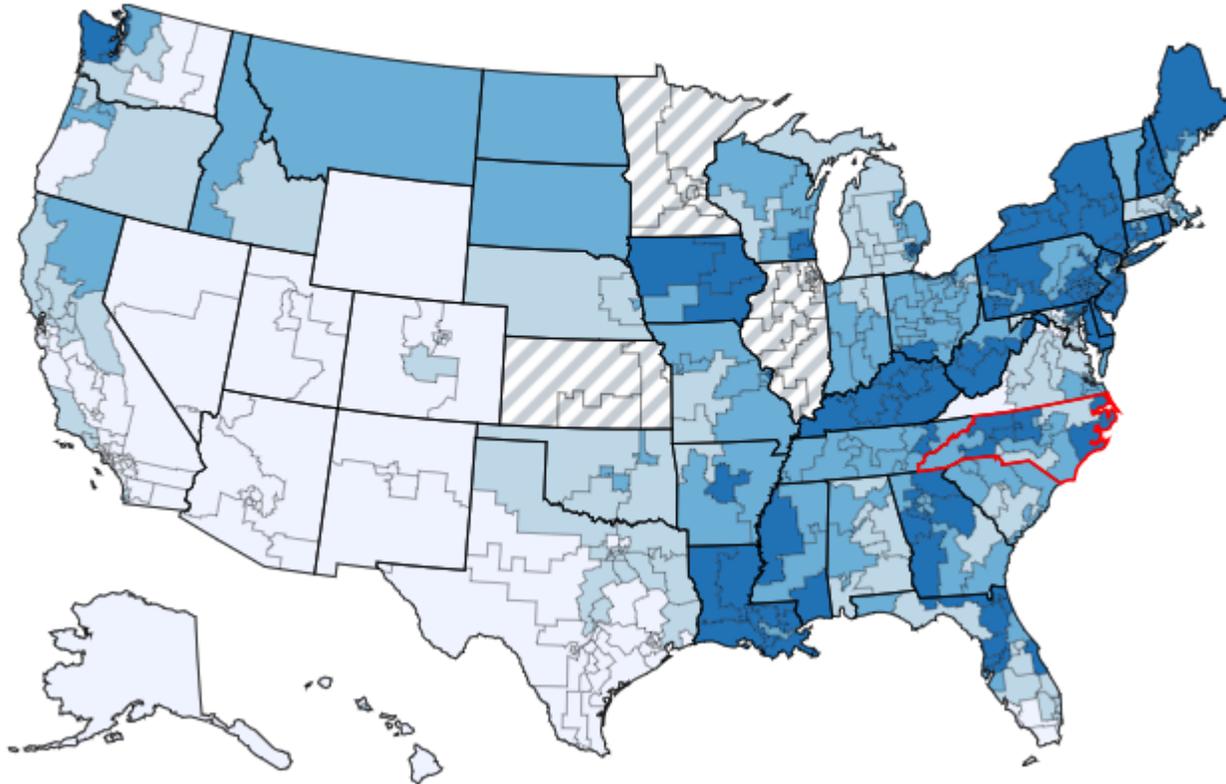
## HOW

far has the cancer spread, and are we catching cancer early?

# Making Data Accessible and Usable

All Types of Cancer, All Races/Ethnicities, Male and Female  
 Estimated rate per 100,000 people

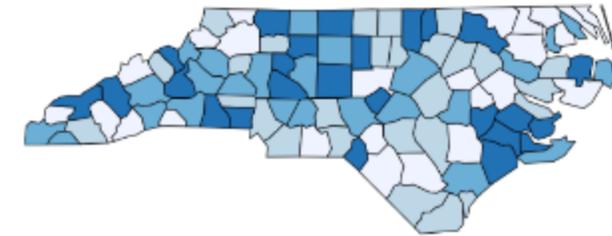
Map Table Export Reset map



gis.cdc.gov/Cancer/USCS/DataViz.html

CDC Centers for Disease Control and Prevention  
 CDC 24/7 Saving Lives. Protecting People™

Rate of New Cancers in North Carolina  
 All Types of Cancer, All Ages, All Races/Ethnicities, Male and Female, 2012-2016



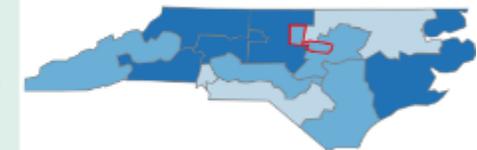
Rate per 100,000 people  
 Data source - U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool, based on November 2018 surveillance data (1999-2016); U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. <https://www.cdc.gov/cancer/uscs/>, June 2019

North Carolina, Congressional District 4, All Types of Cancer, Male and Female, All Races/Ethnicities  
 Estimated rate per 100,000 people

Map Table Export

In Congressional District 4, North Carolina, from 2012-2016, there were an estimated 17,400 new cases of cancer. For every 100,000 people, 459 new cancer cases were estimated.

Over those years, there were an estimated 5,052 people who died of cancer. For every 100,000 people in Congressional District 4, North Carolina, an estimated 146 died of cancer.



# Understanding the AI/AN Cancer Burden

**United States Cancer Statistics: Data Visualizations**  
The official federal statistics on cancer incidence and deaths, produced by the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI).

Technical Notes | Download Data | Archive | Cancer Data and Statistics Tools | About USCS | Questions and Answers | Glossary

Overview | Demographics | Trends | State/Country | Congressional Districts | Survival | Prevalence | Risk Factors | **More Topics** | Related Data

Choose Database: AI/AN restricted to PRCDA only | Choose IHS Region: East | Sex: Male and Female | Cancer Type: All Cancer Sites Combined

### Rate of New Cancers in American Indian/Alaska Native\* East, United States, 2012-2016 All Cancer Sites Combined, Male and Female

\*Data are restricted to non-Hispanic American Indian/Alaska Native living in IHS Purchased/Referred Care Delivery Area (PRCDA) counties.

To improve accuracy of American Indian/Alaska Native (AI/AN) cancer statistics, analyses are restricted to areas with health care services provided by Indian Health Service (IHS). IHS Purchased/Referred Care Delivery Areas (PRCDA) consist of counties which include all or part of an AI/AN reservation and any county or counties which have a common boundary with a reservation. These cancer incidence data are restricted to populations residing in PRCDA counties (defined in the April 7, 2016 [Federal Register](#)) and are grouped at the IHS Region level.

Non-Hispanic whites living in PRCDA counties are presented for comparison.

**American Indian/Alaska Native, Non-Hispanic**  
Rate of New Cancers by Leading Cancer Sites  
Male and Female, East, United States, 2012-2016  
Rate per 100,000 people

Cancer Site	Rate per 100,000 people
Brain and Other Nervous System	32.9
Colon and Rectum	32.9
Esophagus	3.0
Gallbladder	0.9
Hodgkin Lymphoma	0.3
Kaposi Sarcoma	0.3
Kidney and Renal Pelvis	16.1
Larynx	3.7
Leukemias	15.6
Liver and Intrahepatic Bile Duct	7.1
Lung and Bronchus	47.9
Melanomas of the Skin	5.2

**White, Non-Hispanic**  
Rate of New Cancers by Leading Cancer Sites  
Male and Female, East, United States, 2012-2016  
Rate per 100,000 people

Cancer Site	Rate per 100,000 people
Brain and Other Nervous System	7.4
Colon and Rectum	37.5
Esophagus	5.1
Gallbladder	0.9
Hodgkin Lymphoma	3.2
Kaposi Sarcoma	0.3
Kidney and Renal Pelvis	17.1
Larynx	3.7
Leukemias	15.6
Liver and Intrahepatic Bile Duct	7.1
Lung and Bronchus	69.3
Melanomas of the Skin	26.9

Select "AI/AN restricted to PRCDA" only



Select "More Topics" tab

Choose IHS Region

- All IHS Regions
- Alaska
- East
- Northern Plains
- Pacific Coast
- Southern Plains
- Southwest

New Cases (Incidence)

- Rate of New Cases
- Number of New Cancers

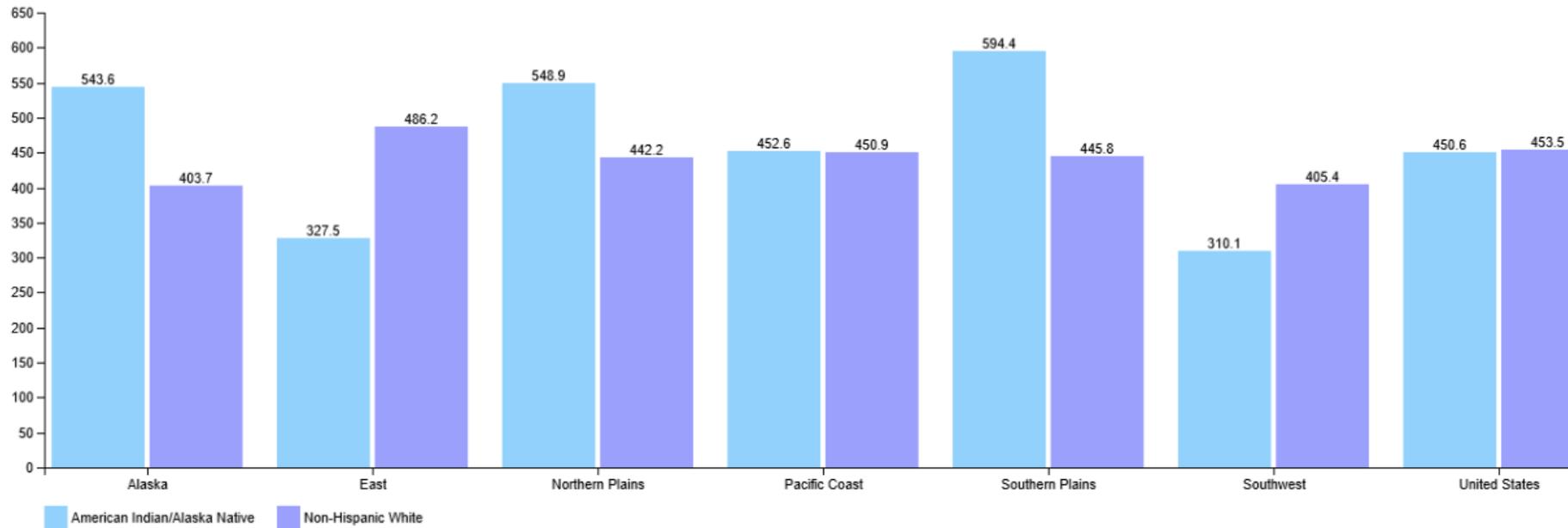
- Cancer Type
- All Cancer Sites Combined
  - Brain and Other Nervous System
  - Cervix
  - Colon and Rectum
  - Corpus and Uterus, NOS
  - Esophagus
  - Female Breast
  - Gallbladder
  - Hodgkin Lymphoma
  - Kaposi Sarcoma
  - Kidney and Renal Pelvis
  - Larynx
  - Leukemias
  - Liver and Intrahepatic Bile Duct
  - Lung and Bronchus
  - Melanomas of the Skin
  - Mesothelioma
  - Myeloma
  - Non-Hodgkin Lymphoma
  - Oral Cavity and Pharynx
  - Ovary
  - Pancreas
  - Prostate
  - Stomach
  - Testis
  - Thyroid
  - Urinary Bladder

# Incidence Rates by IHS Regions



American Indian/Alaska Native, Non-Hispanic, United States, 2012-2016

Rate of New Cancers by IHS Region and Sex



Rate per 100,000 people

Data source – U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2018 submission data (1999-2016); U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; <https://www.cdc.gov/cancer/dataviz>, June 2019.

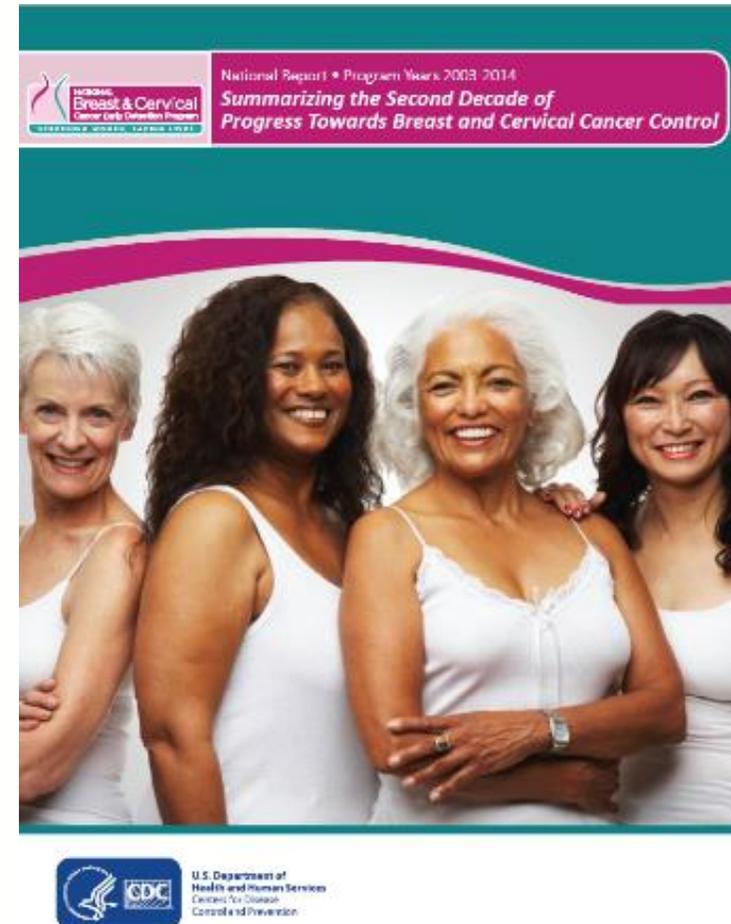
# Scaling Proven Cancer Prevention and Control Strategies



# NBCCEDP Clinical Services Delivered

## Since 1991...

- 5.6 million women served
- 13.3 million screenings
- 68,486 breast cancers
- 21,852 premalignant breast lesions
- 4,720 invasive cervical cancers
- 214,652 premalignant cervical lesions

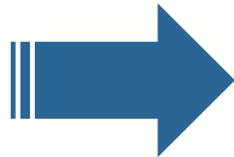


# By the Numbers

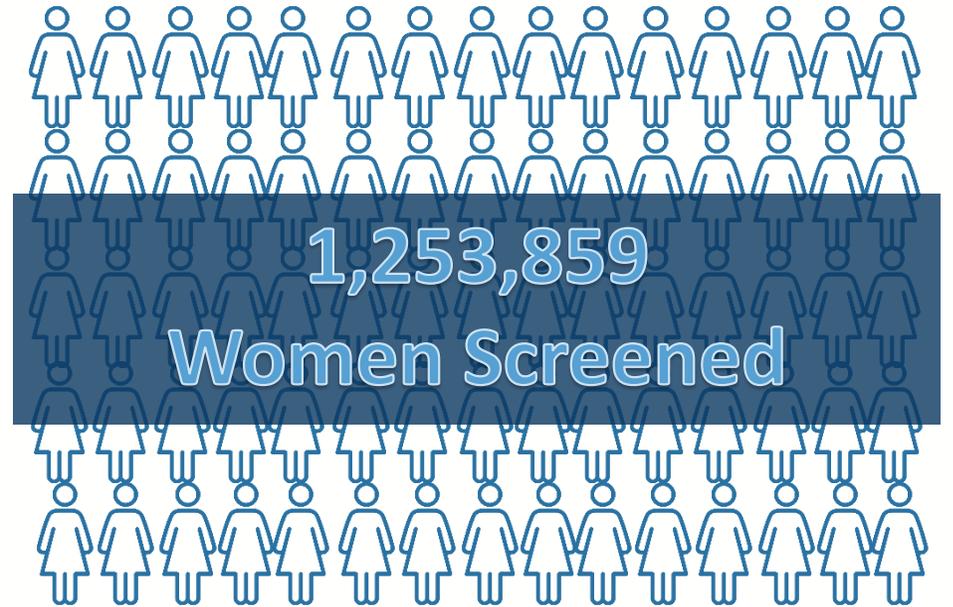
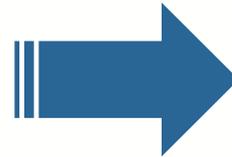
NBCEDP PY2013-PY2018



70 grantees



System-level  
interventions



12,132  
diagnosed breast  
cancers

560  
diagnosed  
cervical cancers

6,436 high-grade  
precancerous  
lesions

# Impact of the NBCCEDP Implementation in NM

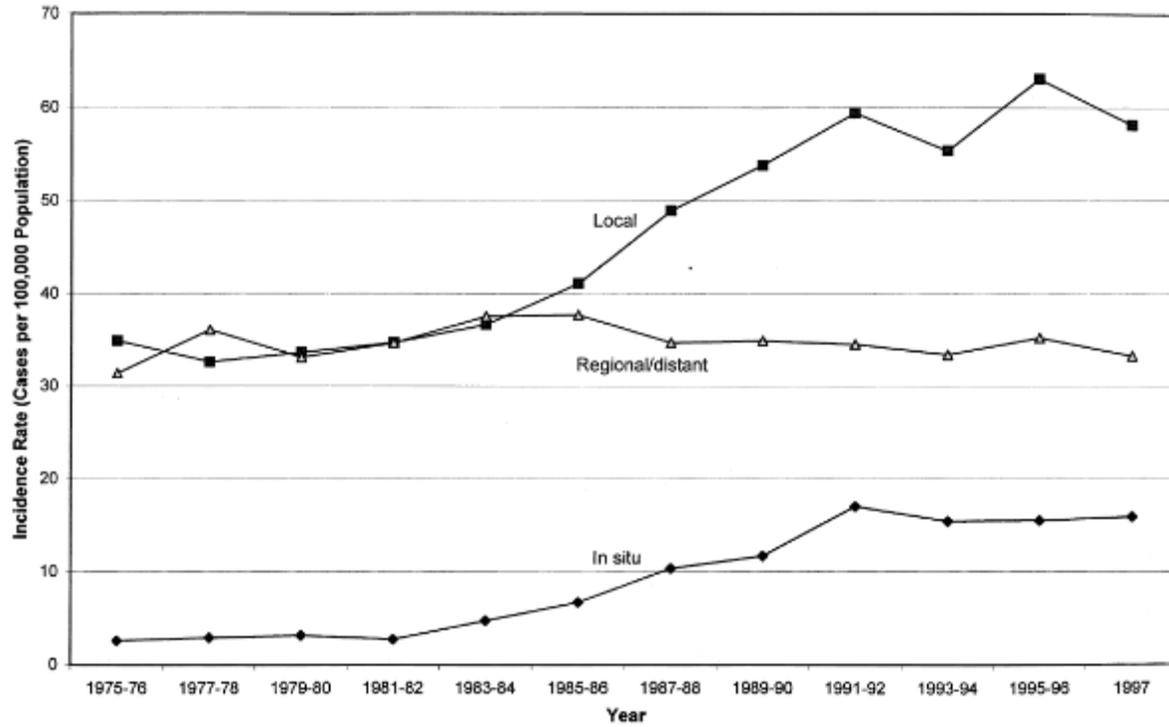


Fig. 1. Breast cancer incidence rate by stage, Surveillance Epidemiology, and End Results Program, New Mexico.

Escobedo et al., Cancer Causes and Control 13: 137–145, 2002.

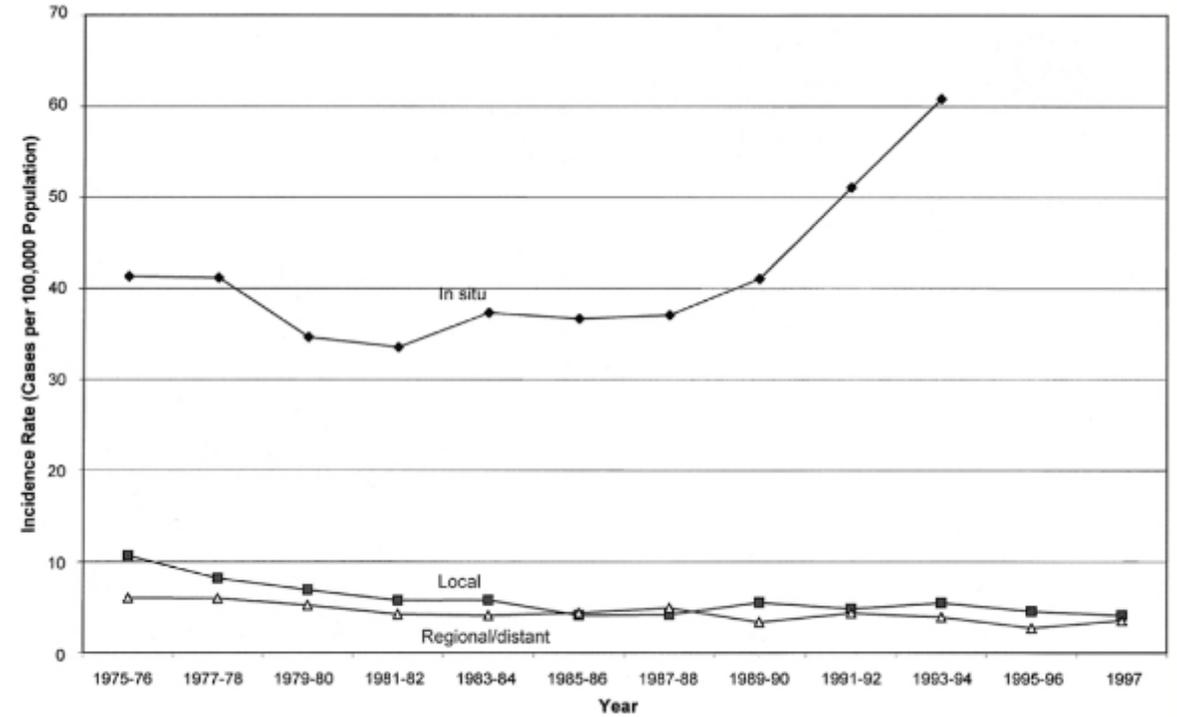


Fig. 2. Cervical cancer incidence rate by stage, Surveillance Epidemiology and End Results Program, New Mexico.

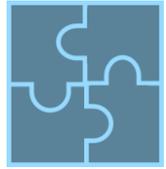
# Analyses of Life Years Gained From Select Population-based Prevention Programs

Intervention	Target Population	LYs saved per person/ year	Data sources, yr
Quitting cigarette smoking	35-year-olds	0.667–0.833	Wright JC, 1998
All childhood immunizations	<5 years old	0.1233	Maciosek MV, 2010
NBCCEDP–Breast cancer screening	40-64 years	0.056	Hoerger TJ, 2011
NBCCEDP–Cervical cancer screening	18-29 years	0.023	Ekwueme DU 2014
NBCCEDP–Cervical cancer screening	30-39 years	0.01	Ekwueme DU 2014
Measles vaccine	<5 years old	0.008	Wright JC, 1998
Rubella vaccine	<5 years old	0.008	Wright JC, 1998
NBCCEDP–Cervical cancer screening	18-64 years	0.006	Ekwueme DU 2014
Breast cancer screening	50+ year-old women	0.0045	Maciosek MV, 2010
Colorectal cancer screening	50 +years FOBT	0.0041	Maciosek MV, 2010
NBCCEDP–Cervical cancer screening	40-64 years	0.003	Ekwueme DU 2014
Influenza immunization	50 + years	0.0024	Maciosek MV, 2010
Cervical cancer screening	21+ years women	0.0002	Maciosek MV, 2010



**So what?**

# Tenets of the CRCCP model



**Integrate public health  
and primary care**



**Focus on defined,  
high-need populations**



**Establish partnerships to  
support implementation**



**Implement sustainable  
health system changes**



**Use evidence-based  
strategies to maximize  
limited public health dollars**



**Encourage innovation in  
adaptation of EBIs**



**Use data for program  
improvement and  
performance management**

# CRCCP Grantee Reach



**245**

Health  
systems



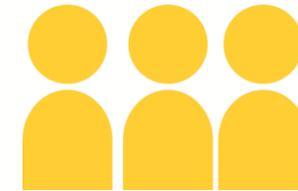
**815**

Clinics



**6,181**

Providers



**1,272,003**

Patients  
aged 50-75

Source: Clinic data submission, Sep. 2019, (Includes clinics recruited in PYs 1-4)

# A closer look at CRCCP clinics



**815**  
**CRCCP**  
**Clinics**

**71%**

are Federally-  
Qualified Health  
Centers (FQHCs)

**27%**

serve high  
percentages of  
uninsured patients  
(>20%)

**51%**

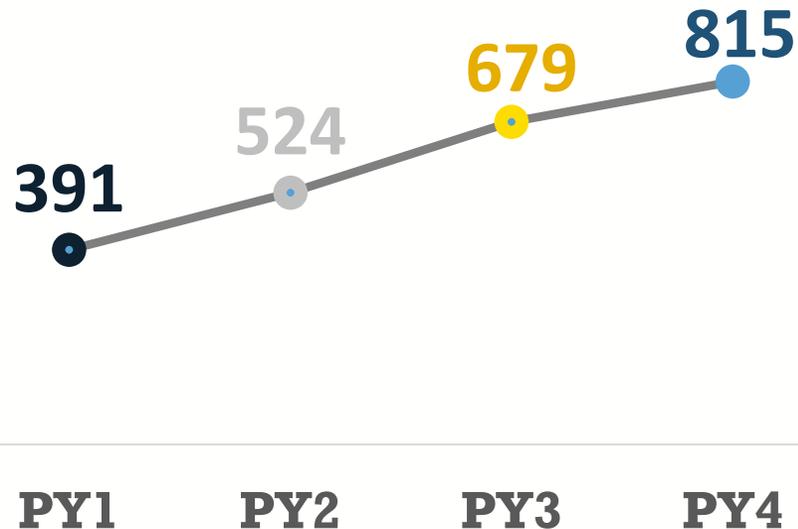
use FOBT/FIT tests  
as the primary CRC  
screening test type

Source: Clinic data submission, Sep. 2019, (Includes clinics recruited in PYs 1-4)

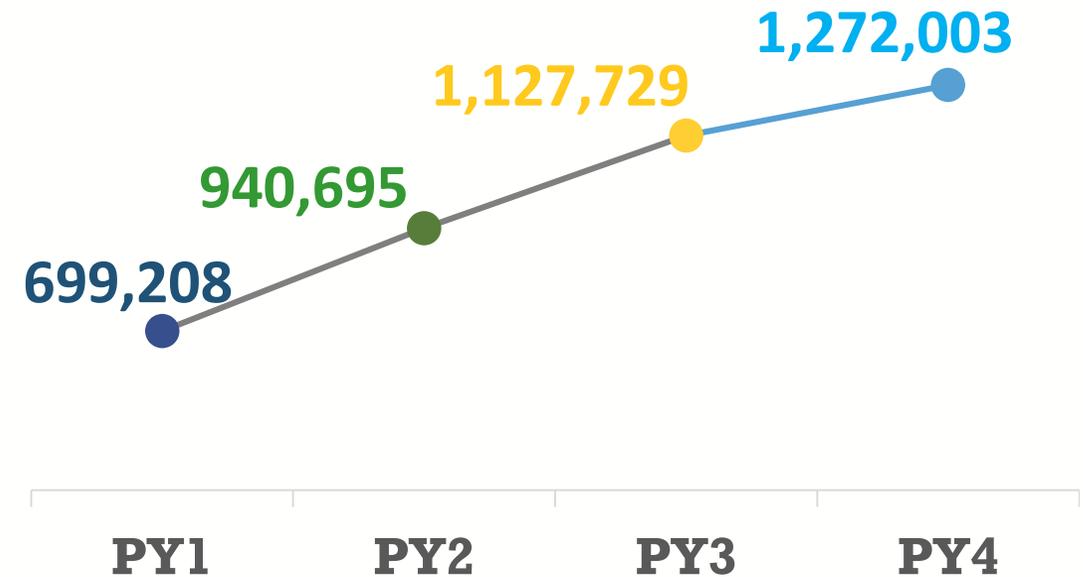
# Reach continues to grow as new clinics are recruited.



This graph shows growth in the # of clinics

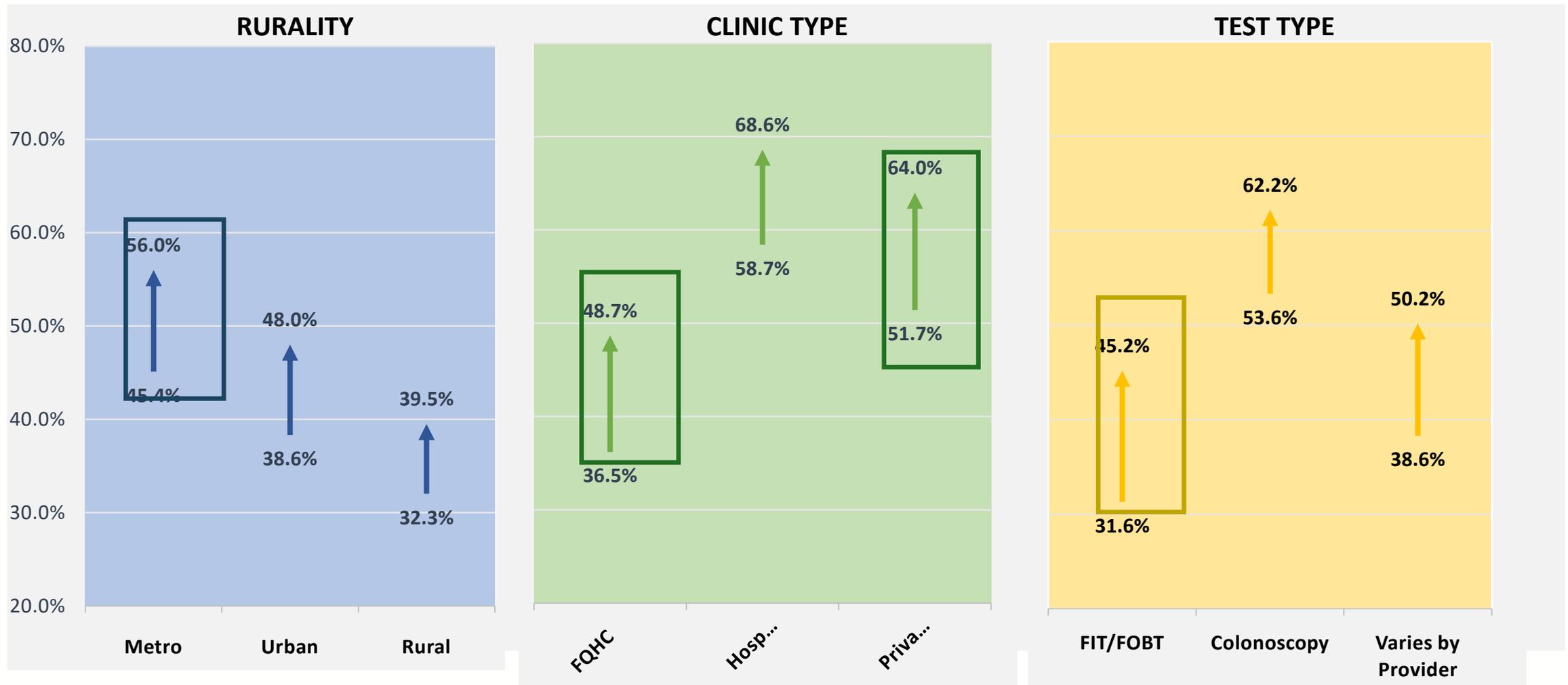


This graph shows growth in the # of patients, age 50-75



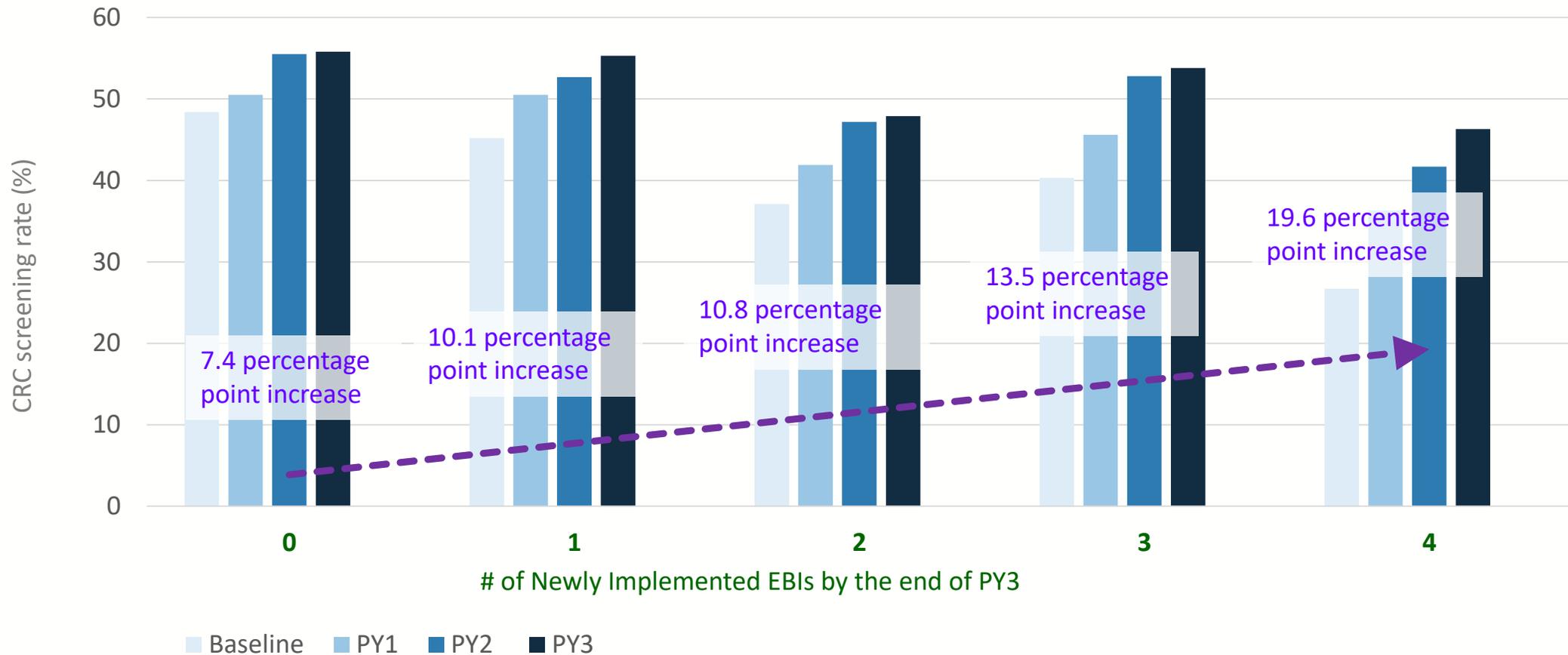
Source: Clinic data submission, Sep. 2019, (Includes clinics recruited in PYs 1-4)

# Screening rate increases from PY1 to PY3 vary by clinic characteristics



Source: CRCCP Clinic Data April, 2019 data submission. PY1 Clinics only; Years 1-3.

# CRC screening rates through PY3 increase with each newly implemented with EBI



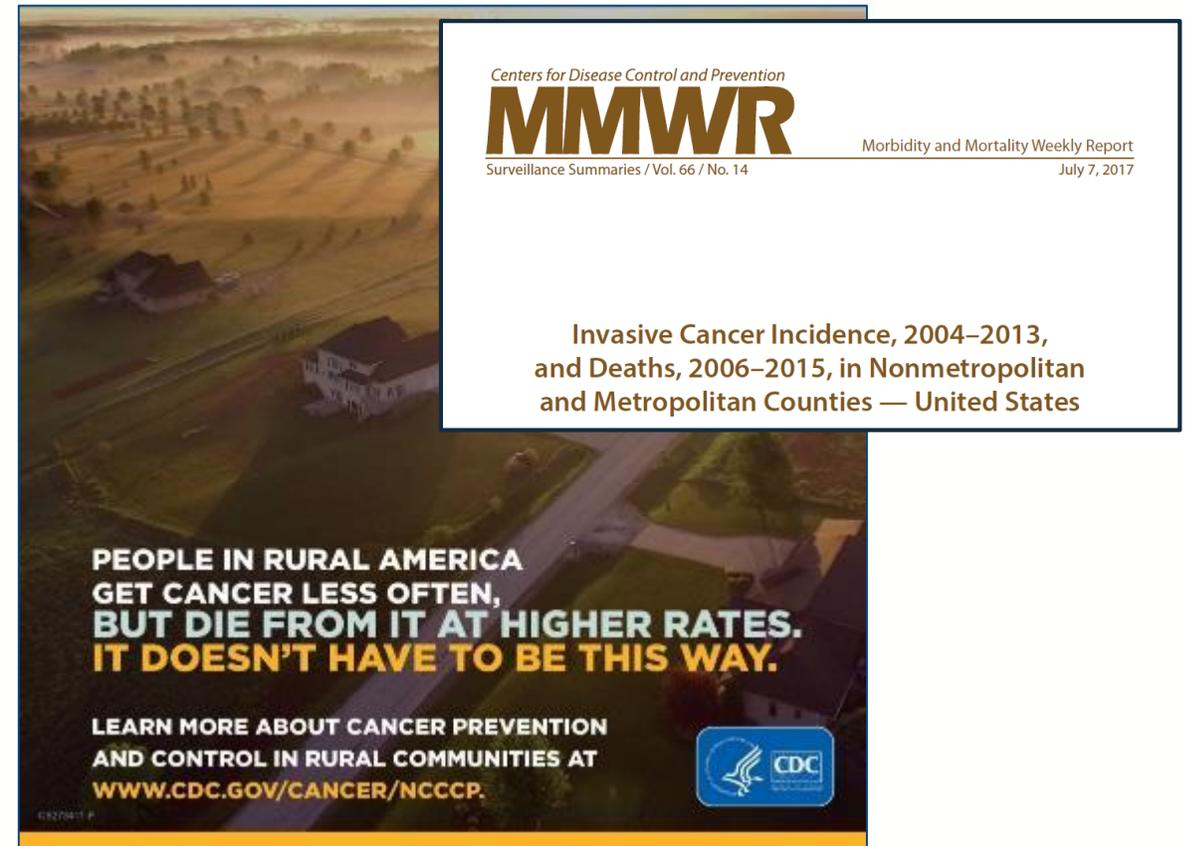
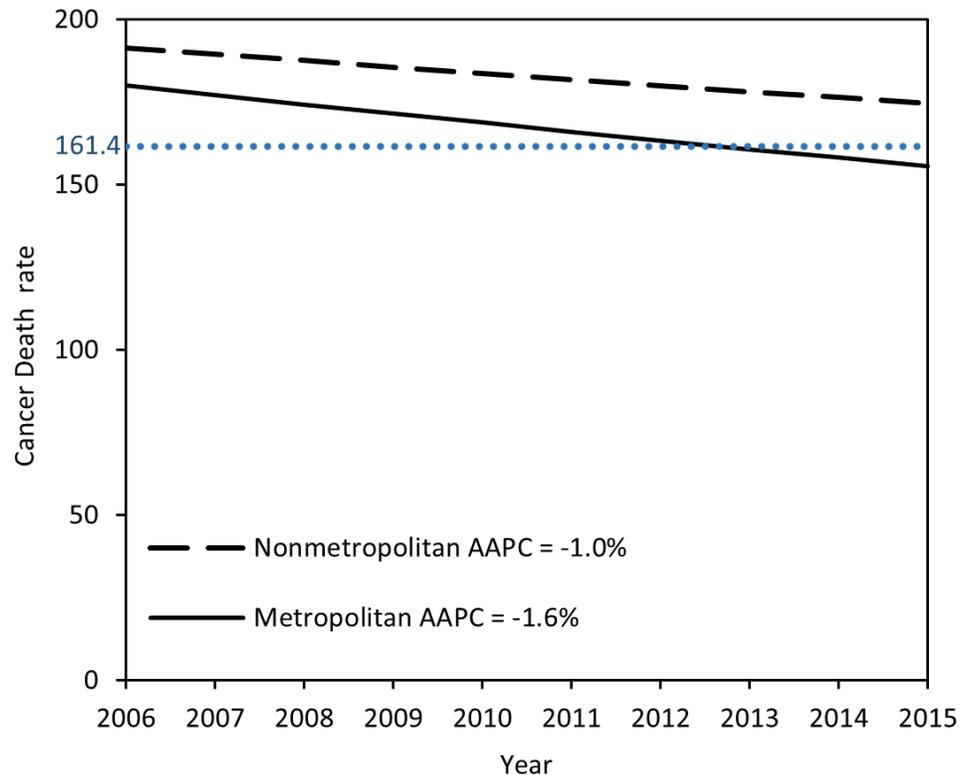
Source: CRCCP Clinic Data April, 2019 data submission. PY1 Clinics only; Years 1-3.

# Supporting Community Champions



# CDC Rural Health Series

MMWR First to detail cancer differences and mortality gaps between rural and urban areas



Henley SJ, Anderson R, Thomas CC, Massetti GM, Peaker B, Richardson LC. Invasive cancer incidence, 2004–2013, and deaths, 2006–2015, in non-metropolitan and metropolitan counties — United States. MMWR Surveill Summ 2017;66:1–13

# Addressing Research/Clinical Trial Enrollment Gaps

Rapid Case Ascertainment (RCA) of the North Carolina Central Cancer Registry Partnership



## By the Numbers

Since 1992:

- **20,000** patients enrolled in research studies in NC and nationwide
- **200,000** path reports reviewed/identified
- **30** studies spanning **15** cancer sites.
- Hospital report reimbursement reinvested in registry program education & improvements

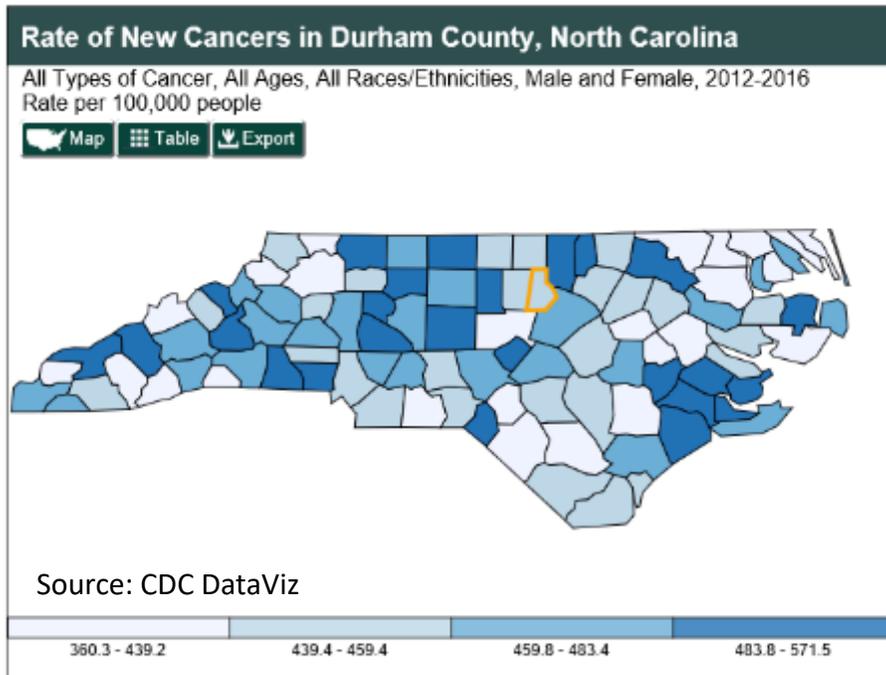


LINEBERGER COMPREHENSIVE  
CANCER CENTER



# Linking Vulnerable Populations to Critical Services

Collaborating to navigate uninsured, minority women to local screening programs



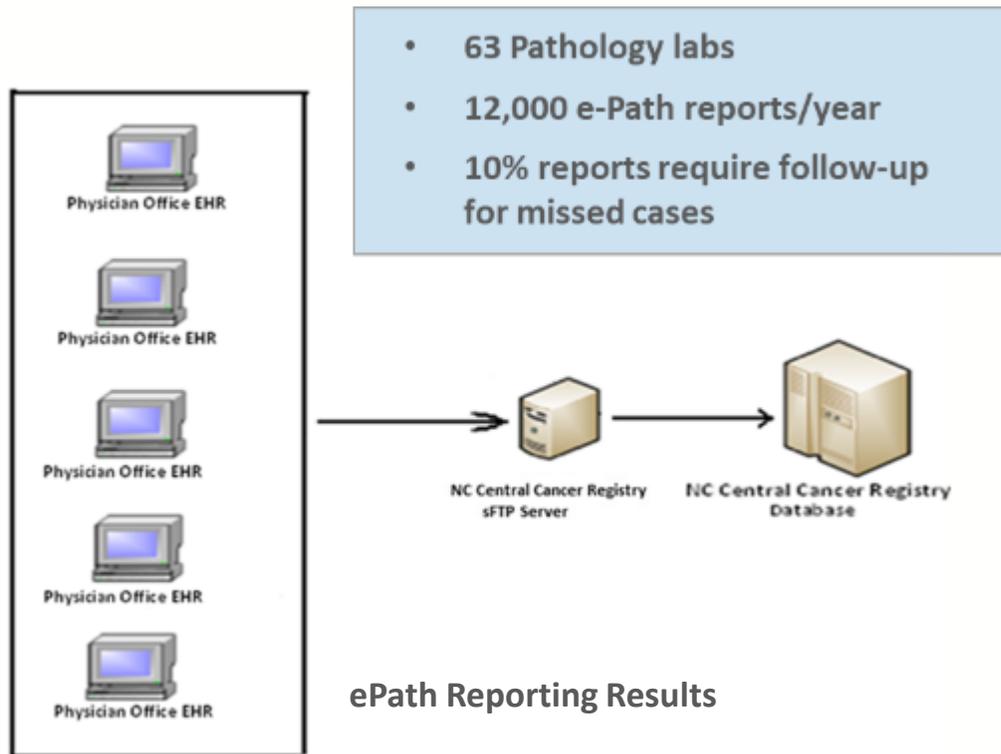
**70%**  
 Durham County residents have health care access and insurance concerns

**15.1%**  
 Durham County women ages 18-64 uninsured



# Every Case Counts: Facilitating Efficient Electronic Reporting

Improving the completeness, timeliness, and quality of physician/clinic cancer data



## Meaningful Use (MU) Reporting Results

<b>MU files received for 2014-2016 diagnoses</b>	<b>3,452</b>
<b>Non-matches after linkage to registry database (cases not reported by the practice)</b>	<b>4,649</b>
<b>Cases with a non-reportable condition</b>	<b>3</b>
<b>Multiple records combined into a single record for the patient and tumor</b>	<b>3,261</b>
<b>Cases loaded into the final registry database</b>	<b>1,385</b>
<b>MU files received for 2017 diagnoses</b>	<b>1,500</b>
<b>Cases with a non-reportable condition</b>	<b>1</b>
<b>Multiple records combined into a single record for the patient and tumor</b>	<b>338</b>
<b>Cases loaded into the final registry database</b>	<b>836</b>

**835% increase  
over 2013**



# Planning for Success



# All People Free of Cancer

## Aspirations

### PREVENTION

Eliminate preventable cancers



### SCREENING

All people get the right screening at the right time for the best outcome



### CANCER SURVIVORS

Cancer Survivors live longer, healthier lives



## Strategic Priorities

Reduce risk of cancer

Scale best practices to increase screening outcomes

Improve health and wellbeing for cancer survivors

## Guiding Principles

*Equity*

*Begin with the End in Mind*

*Collaboration*

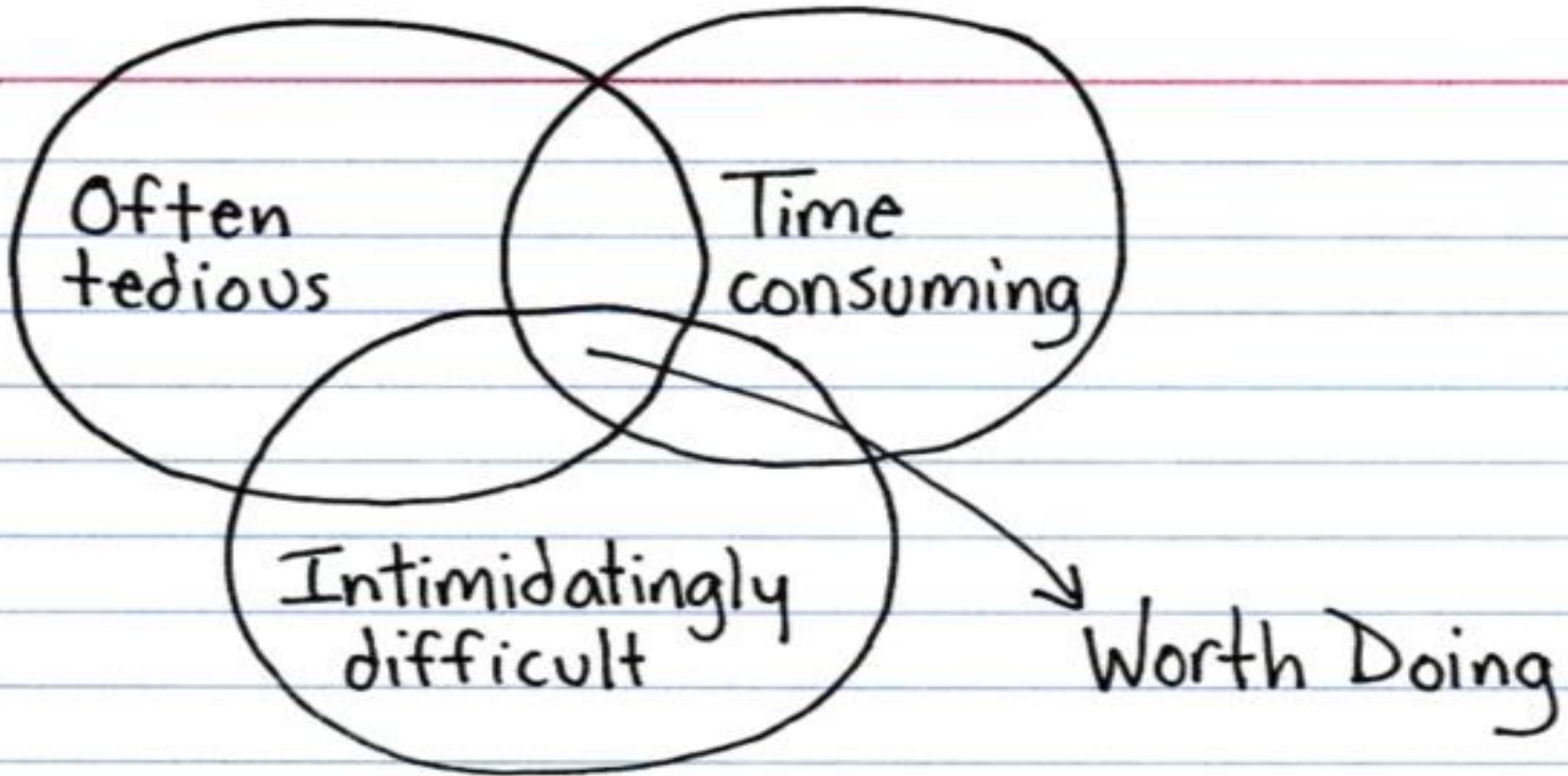
*Targeted Communications*

## Strengths

*Data*

*Translation & Evaluation*

*Partnership*



# Thank you!

Go to the official federal source of cancer prevention information:  
[www.cdc.gov/cancer](http://www.cdc.gov/cancer)

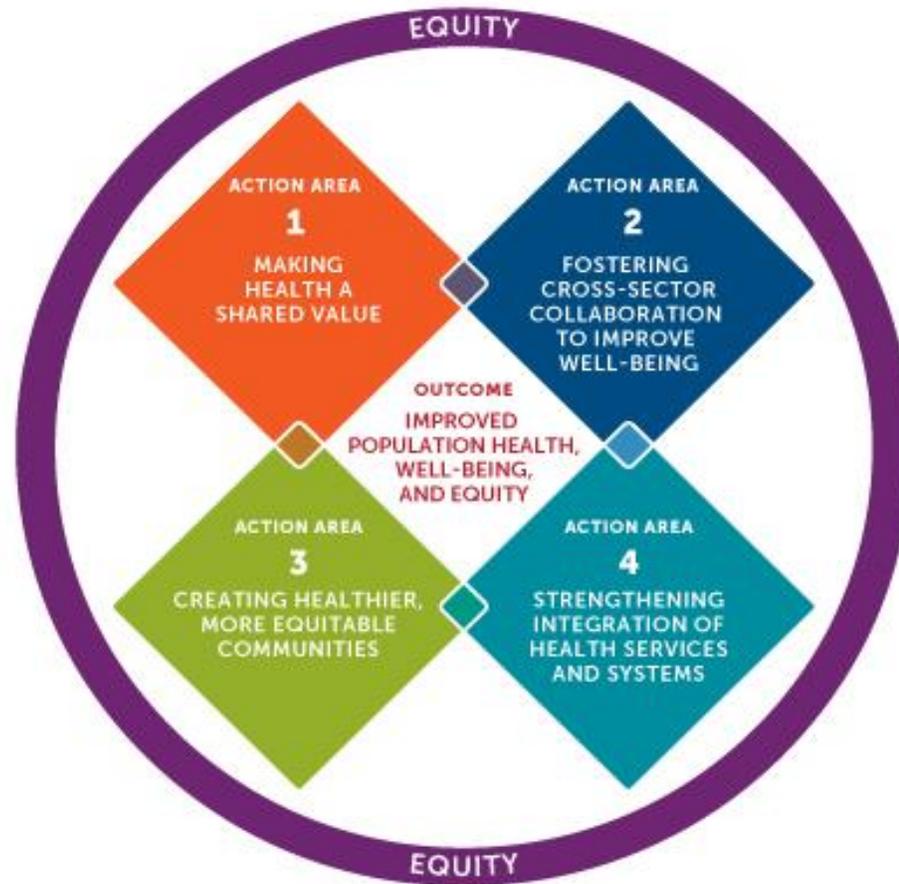


Division of Cancer Prevention and Control

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*The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.*

# Building a Framework for a Culture of Health



Source: [rwjf.org/en/culture-of-health/2015/11/measuring\\_what\\_matte.html](http://rwjf.org/en/culture-of-health/2015/11/measuring_what_matte.html)

